



WOMEN'S HEALTH CHECK EMANUAL



IDAHO DEPARTMENT OF
HEALTH & WELFARE

ABOUT THE . . . WOMEN'S HEALTH CHECK MANUAL

PURPOSE

This manual is a working guide for the day-to-day administration of providing breast and cervical cancer screening and diagnosis to older, uninsured women with limited family income and no other resources for these services.

The purpose of this manual is to describe the policies and procedures for contractors and providers of the Women's Health Check Program (WHC), a breast and cervical cancer screening program administered through the Bureau of Clinical and Preventive Services, Division of Health, Department of Health and Welfare and funded by Centers for Disease Control and Prevention through a cooperative agreement.

The National Breast and Cervical Cancer Early Detection Program ([NBCCEDP](#)) is a landmark program that brings critical breast and cervical cancer screening services to medically underserved women. Early detection can reduce breast and cervical cancer mortality.

Questions related to the Women's Health Check Program should be directed to [State WHC staff](#) or Local Coordinating Contractors ([LCC](#)).

AUDIENCE

The primary audience for the Women's Health Check Manual consists of health care professionals located throughout the state that are involved in the process of delivering services to clients eligible for breast and cervical cancer screening and diagnosis through Women's Health Check.

CONTENT OVERVIEW

This manual offers providers a concise resource for managing Women's Health Check clients. Service summaries, forms, instructions, protocols, and case management requirements are all included. We hope that this manual will aid you in understanding the important part you play through providing Women's Health Check services.

Eligibility And Enrollment



2008 Women's Health Check Eligibility Guidelines

Women must meet the following WHC eligibility criteria:

- Low Income (see table below)
- No health insurance coverage for Pap tests or mammograms
- Age 50-64 for Pap test, clinical breast exam and mammogram **or**
- Age 40-49 for Pap test.

Note: Women who have never had a Pap test or not had a Pap test in the last 5 years are at high risk for cervical cancer and are a priority for enrollment.

- Women over age 65 who are NOT eligible for Medicare or cannot afford Medicare Part B
- **Limited enrollment and services** available for uninsured women who meet these additional criteria:
 - Age 30 – 49 and have symptoms suspicious of breast cancer confirmed by a health care professional
 - Age 30 – 39 and have symptoms suspicious of cervical cancer confirmed by a health care professional

< 200% of Federal Poverty Level

Persons in Family Unit	Annual	Monthly
1	\$20,800	\$1,733
2	\$28,000	\$2,333
3	\$35,200	\$2,933
4	\$42,400	\$3,533
5	\$49,600	\$4,133
6	\$56,800	\$4,733
7	\$64,000	\$5,333
8	\$71,200	\$5,900
For each additional person, add	\$7,200	\$600

SOURCE: Federal Register, Vol. 73, No. 15, January 23, 2008, pp.3971-3972

Women's Health Check is a breast and cervical cancer screening program.

Women's Health Check provides Mammogram, Clinical Breast Exam, and/or Pap test for women who have no other resources for annual screening.

www.healthandwelfare.idaho.gov

Click on Women's Health Check





Guías de Elegibilidad 2008

Chequeo de Salud para Mujeres

Las mujeres deben llenar las siguientes medidas de elegibilidad del programa WHC:

- Ingresos bajos (ver cuadro abajo)
- No tener cobertura de seguro de salud para las pruebas del Papanicolaou ni para mamografías
- Tener entre 50-64 años de edad para la prueba del Papanicolaou, el examen clínico de los senos y la mamografía
- Tener entre 40-49 años de edad para la prueba del Papanicolaou.
- Las mujeres que son mayores de 65 años de edad que NO son elegibles para Medicare o no pueden pagar la Parte B de Medicare
 - **Matrículas y servicios limitados** están disponibles para las mujeres sin seguro que llenan estos criterios adicionales:
 - Tener entre 30 – 49 años de edad y tener síntomas sospechosos de cáncer del seno confirmados por un profesional del cuidado de la salud
 - Tener entre 30 – 39 años de edad y tener síntomas sospechosos de cáncer cervical confirmados por un profesional del cuidado de la salud

Nota: Las mujeres que no se han hecho una prueba del Papanicolaou o no han tenido esa prueba en los últimos 5 años corren un riesgo alto de tener cáncer cervical y tienen prioridad para registrarse

< 200% del Nivel Federal de la Pobreza

Personas en la Unidad Familiar	Anual	Mensual
1	\$20,800	\$1,733
2	\$28,000	\$2,333
3	\$35,200	\$2,933
4	\$42,400	\$3,533
5	\$49,600	\$4,133
6	\$56,800	\$4,733
7	\$64,000	\$5,333
8	\$71,200	\$5,900
Para cada personal adicional, agregar	\$7,200	\$600

FUENTE: Registro Federal, Vol. 73, No. 15, Enero 23, 2008, pp. 3971-3972

El Chequeo de Salud para Mujeres (WHC por sus siglas en inglés) **es un programa de evaluación del cáncer del seno y del cáncer cervical.** Este programa provee mamografías, exámenes clínicos de los senos y pruebas del Papanicolaou para mujeres que no tienen otros recursos de evaluación anual.

www.healthandwelfare.idaho.gov

Haga clic en el Chequeo de Salud para Mujeres (*Women's Health Check*)



WOMEN'S HEALTH CHECK CLIENT ENROLLMENT

Women shall be determined eligible for Women's Health Check (WHC) prior to receiving screening or diagnostic services.

ENROLLMENT

Every enrollment site shall be provided with WHC Client "Welcome" and annual "Welcome Back" packets.

- Staff at enrollment site shall maintain communication with LCC as to availability of resources or current waiting lists.
- Staff at enrollment site shall interview potentially eligible women to determine if they qualify for *WHC*, and would choose to enroll.
 - Staff checks eligibility and initials enrollment form to verify eligibility.
 - Client completes and signs Enrollment form.
 - Staff and client review Intake Assessment form, client initials and keeps copy.
- Staff shall instruct client to carry her *WHC* Enrollment card to all WHC related appointments, and present at front desk to photocopy for billing.
- Every year, client must complete and sign enrollment form in Welcome or Welcome Back packet, verifying her eligibility.

ELIGIBILITY QUESTIONS

1. Income:

- What is your total household income before taxes? (Includes wages, unemployment or disability benefits, child support, tips, wages, personal income from any business activity)
- How many people live in the household or are supported by the income listed above?

Use responses from questions above to determine income eligibility by comparing information to [WHC Eligibility Guidelines](#).

2. Insurance:

- Do you have any health insurance? (purchased individually, through employer, through any group plan, Medicaid, Medicare) If yes and younger than priority ages, do not enroll.

For Priority Screening Population (see below):

- If you have insurance or health care plan, does it cover preventative health services such as annual exams, mammograms, Pap tests?
 - If the client indicates that the deductible on her health insurance prevents her from obtaining a mammogram or Pap test, local staff may enroll client due to an insurance barrier, as long as she is in priority age group for screening.
 - Younger women referred for diagnostic tests are not eligible if they have any other health care insurance or resource for payment.

3. Priority Screening Populations (75% of those enrolled)

- Are you age 50 - 64? (Breast Cancer Screening Priority for Mammogram and CBE)
- Are you age 40 - 64? (Cervical Cancer Screening Priority for Pap and Pelvic exam)

- Especially who have never had a Pap test or not had a Pap test in 5 or more years
- If over age 64, are you eligible for Medicare?
 - If eligible for Medicare, have you elected Medicare Part B and paid the premium?
 - Some women over age 65 are not eligible for Medicare due to no work record – for example a wife of a sheepherder who never received wages.
 - Some women cannot afford to pay the premium for Medicare Part B, and are therefore eligible for *WHC*. (They should be strongly encouraged to enroll in Medicare Part B if at all possible since it provides much broader care than *WHC*.)

4. **Limited Enrollment and Services for women who are: (25% of those enrolled)**

- Between the ages of 40 – 49 to qualify for breast cancer screening, women must additionally:
 - Have symptoms suspicious of breast cancer (clinician must complete approval form, [Limited Enrollment Approval](#) and submit with enrollment).
 - Have a personal history of breast cancer (clinician must submit form, [Limited Enrollment Approval](#)).
 - Have NO health care insurance.
- Between the ages of 30 – 39 to qualify for breast cancer screening, women must additionally:
 - Have symptoms suspicious of breast cancer (clinician must complete approval form, [Limited Enrollment Approval](#) and submit with enrollment).
 - Have NO health care insurance.
- Between the ages of 30 – 39 to qualify for cervical cancer screening, women must additionally:
 - Have symptoms suspicious of or at increased risk for cervical cancer (clinician must submit form, [Limited Enrollment Approval](#)).
 - Have NO health care insurance.

5. **Prior Enrollment:**

- In some sections of the state, coverage areas of [LCC](#)'s overlap and clients may move from one LCC area to another.
 - Ask client if they have previously received *WHC* services. If yes, it is the responsibility of the LCC determining eligibility to obtain prior records before scheduling client appointments.
 - LCC can query the *WHC* Real Time database to determine if the client has previously enrolled at another site.

*According to federal law, men are not eligible for *WHC*. Although a small percentage of men may develop breast cancer, the funding for this program is intended for screening the population at increased risk of breast and cervical cancer. Population based screening for men is not recommended.

Note: Completed and signed [Enrollment Form](#) must be submitted to LCC within 24 hours. The LCC shall enter enrollment information into *WHC* electronic database within 1 week of services provided.

Healthcare Professionals

HEALTHCARE PROFESSIONALS

Women's Health Check (WHC) client services are provided through a network of Local Coordinating Contractors ([LCC](#)) and over 300 health care providers.

Through the partnership and dedication of all of the healthcare professionals that provide services and case management, *WHC* fills a critical gap in the screening and early detection of breast and cervical cancer in Idaho.

LIABILITY

"Medical Malpractice and Breast Cancer Evaluation" R. James Brenner, MD, JD, FACR

"Delay in diagnosis of breast cancer is the most common reason that physicians are sued for malpractice, the most commonly named defendant being the radiologist and the greatest indemnity awards relating to primary care physicians. Reasonable clinical examinations with appropriate medical record documentation combined appropriate imaging studies and deliberate management plans form the basis for risk management. An awareness of the interaction between these two disciplines with respect to both limitations and potential of imaging and physical examination is essential to the aspect of legal liability and causation..."

Standard of care includes:

- Appropriate history and risk factors,
- Documented complete screenings and diagnostic work-up,
- Recall mechanisms in place.

Following the procedures required by *WHC*, utilizing the *WHC* electronic database and case management system will reduce the chance for delayed or missed follow-up of abnormal results. This also assists with documentation of appropriate procedures and results.

LOCAL COORDINATING CONTRACTOR REQUIREMENTS

Women's Health Check (WHC) client services are provided through a network of Local Coordinating Contractors (LCC) and over 300 health care providers. Each LCC contracts with the State of Idaho, *Women's Health Check* program to recruit and enlist local providers, recruit and enroll clients, obtain and record data, and to provide timely and adequate [case management](#).

PROVIDER RECRUITMENT

- Identify and enlist qualified local providers for annual exams, mammograms, laboratory tests, and for diagnostic referrals.
- Submit names of providers to state *WHC* office for Memorandum of Agreement (MOA).
- Maintain regular communication with providers regarding changes, updates, new information, and publications relating to *WHC*.

CLIENT RECRUITMENT

- Conduct local outreach activities to recruit and enroll [eligible](#) women of [priority age](#) for screening.
- Ensure *WHC* Client Welcome and Welcome Back packets are at each enrollment site.
- Oversee client eligibility and enrollment.
- Monitor number of clients enrolled and returning for annual [rescreening](#) according to current contract.
- Utilize waiting lists to monitor enrollment of priority screening population without exceeding available resources.

RECORDS AND DATA

- Establish and maintain client records containing all required data.
- Enter data into *WHC* Real Time system.
- Ensure timely and appropriate follow-up and case management through weekly monitoring of all reports in *WHC* Real Time system.
- Ensure client data is entered as soon as available.

CASE MANAGEMENT

- Provide/oversee case management for clients with unusual needs.
- Provide/oversee appropriate case management for women with abnormal test/exam results.
- Ensure timely diagnosis and referral to BCC Medicaid Treatment or assist with other arrangements.
- Ensure women do not "fall through the cracks" of the system by addressing barriers that prevent them from screening, diagnostic, or treatment for breast or cervical cancer.
- Use due diligence to reduce the risk of litigation by:
 - Ensuring that there are no more than 60 days between abnormal findings and diagnosis, no more than 60 days between diagnosis and treatment.
 - Following [standards](#) of practice.

PROVIDER REQUIREMENTS

Women's Health Check (WHC) client services are provided through a network of Local Coordinating Contractors ([LCC](#)) and over 300 health care providers. All providers agree to utilizing [approved procedures](#) and reporting results for *WHC* clients to [LCCs](#).

REPORTED FINDINGS

- Results of all tests and exams must be submitted to the *WHC* [LCC](#) using [screening/diagnostic forms](#) within 30 days of procedure.

REQUIREMENTS FOR TIMELINESS AND ADEQUACY

- Enrollment forms are submitted to the *WHC* [LCC](#) as soon as possible.
- Claims for exams, tests and procedures shall be submitted within 90 days to the [Third Party Administrator](#) for *WHC*. That agency will pay providers directly for qualifying service (see [WHC eligible codes and current rates](#)), provided by a health care provider who has a current [Memorandum of Agreement](#) with the state *WHC* office, for an enrolled *WHC* client.
- Results of all tests/consults/exams must be provided to the *WHC* Local Coordinating Contractor as soon as possible, at least within 30 days of procedure or exam.
- Mammograms and Clinical Breast Exams (CBE) are required to be within a 60 day interval.

Note: Due to limited *WHC* funding, Clinical Breast Exam, pelvic and collecting Pap specimen should be done at the same visit.

ANNUAL APPOINTMENTS

- Review client's *WHC* responsibility to keep screening and follow-up appointments ([Intake Assessment](#) form and [Enrollment](#) form). Question client about possible barriers to getting the mammogram or other services (beliefs, fear, transportation, childcare etc.).
- Obtain a second contact phone number if not on [Enrollment](#) form.
- Assist client with overcoming any identified barriers.
- Provide appropriate education (importance of Clinical Breast Exam (CBE) together with mammogram for early detection, size of lump found by CBE alone vs. mammogram and CBE, radiation exposure no more than dental x-rays, exposed to more radiation flying coast to coast etc.).
- Make client appointment for mammogram or other services.
- Document in client record.
- Enter data in *WHC* electronic data system.

OTHER

- Client should not be billed for services covered by *WHC*. Contracting providers agree to accept the Medicare rate for the approved [CPT codes](#).
- Any other procedures (not listed for *WHC* [CPT codes](#)) are NOT covered, and the client must be informed prior to the procedure that it will not be paid for by *WHC*. Other arrangements for payment must be made prior to any non-covered services.
- Mammography facility, lab, physician or other healthcare professional must have appropriate certification/licenses for services (ex: MQSA, CLIA-88) and code results according to ACR BI-RADS (mammography) or Bethesda system (Pap).
- *Women's Health Check* [forms](#), or other means of documenting all data on those forms, must be completed accurately for all client services (Screening, Diagnostic, and Consultation). All data on these forms is reported by the state, without client identifiers, to the Centers for Disease Control and Prevention.
- Providers (including mammography facilities, labs, physicians and other health care professionals) must sign a written contract ([Memorandum of Agreement](#)) with the State of Idaho Department of Health and Welfare, *Women's Health Check* Program, before they can be reimbursed for services by the Third Party Administrator for *WHC*.

Note: Providers submit claims to the *WHC* Third Party Administrator, and may NOT bill the client for any portion of the listed services.



MEMORANDUM OF AGREEMENT

The Idaho Division of Health (Women's Health Check) and the undersigned Provider (page 3, this document), desire to enter into an agreement whereby the Provider will provide listed screening and diagnostic tests to women enrolled in the Women's Health Check (WHC) Program, according to the guidelines of the National Breast and Cervical Cancer Early Detection Program.

Background:

U.S. Congress passed Public Law 101-354 in 1992, creating the National Breast and Cervical Cancer Early Detection Program (NBCCEDP). Initially, the program provided education to increase early detection of these cancers. Since 1996, Idaho has been funded to reimburse providers for screening and diagnostic tests provided for eligible clients, enrolled in Women's Health Check.

A limited number of procedures may be reimbursed at Medicare rates for outpatient services (see attached list). No other services shall be reimbursed through this program. Results of all services reimbursed through WHC must be reported to the WHC Local Coordinating Contractor (Health Department or local clinic that has contracted with the State of Idaho to coordinate services and report data).

Provider Responsibilities:

The Provider acknowledges that it may have an obligation, independent of this agreement, to comply with the Health Insurance Portability and Accountability Act (HIPAA), Sections 262 and 264 of Public Law 104-191, 42 USC Section 1320d, and federal regulations at 45 CFR Parts 160, 162 and 164. If applicable, Provider shall comply with all amendments to the law and federal regulations made during the term of the agreement.

The Provider shall provide screening and/or diagnostic services as listed, for women enrolled in WHC, who are referred or in coordination with a WHC Local Coordinating Contractor (LCC). The Provider shall ensure that all services are provided by staff that are appropriately licensed for the service, according to national standards for mammography (MQSA), laboratory (CLIA-88), or professional license. The Provider shall provide proof of current insurance for Workers Compensation and Professional Liability.

The Provider shall provide listed services for WHC enrolled clients at no charge to the client. The Provider may not bill the client for any portion of covered services. The Provider must make other arrangements with the client for payment of any services not covered by WHC.

The Provider shall provide results of all services to the WHC Local Coordinating Contractor as soon as available, and within 30 days of date of service. Results shall be reported according to national standards, utilizing WHC Screening and Diagnostic Forms (see WHC e-Manual) at www.healthandwelfare.idaho.gov.

The Provider shall utilize standard form CMS-1500 or UB-04 to submit claims to WHC's Third Party Administrator, United Group Programs. Required claim information must include:

- Patient Name / Address / Date of Birth / Social Security Number (WHC unique ID number if no SSN available)
- Provider Name / Address / Tax ID Number
- CPT Code / Date of Service / Place of Service / Charges
- Name of WHC Local Coordinating Contractor where patient is enrolled
- All claims should be clearly marked: **"Idaho Women's Health Check"**
- Paper and/or electronic claims shall be submitted to United Group Programs
- For questions about a claim, Provider may contact United Group Programs at 1-800-810-9892, extension 4786 (Shannon Branch)
- Claims shall be billed within 90 days of service to ensure payment
- Procedures that required pre-authorization must have the pre-authorization form attached or faxed with the claim form
- Submit all claims to:

United Group Programs, Inc.
Attention: Idaho Women's Health Check
2500 North Military Trail, Suite 450
Boca Raton, FL 33431

Women's Health Check Responsibilities:

WHC shall provide updated e-Manual, Reimbursement Rate List for covered CPT code services (updated annually), as well as training and information relating to the program.

Local WHC Coordinators will maintain active communication with Providers serving clients they enroll and for which they have responsibility. LCCs provide required data to the state and federal program, with signed release of this information provided by the patient on the WHC Enrollment Form.

WHC shall ensure client confidentiality and HIPAA compliance for clients enrolled in the program.

Patients enrolled and screened through WHC who are later diagnosed with breast or cervical cancer may apply to receive Medicaid for treatment, as long as they meet citizenship or eligible alien standards and do not have insurance. WHC shall submit applications for this treatment to Medicaid.

WHC shall communicate pertinent clinical updates, according to NBCCEDP Policies and Procedures, to maintain program quality.

This agreement may be terminated, amended, changed, or otherwise revised by mutual agreement, at the initiation of either party, with 30 days written notice to the other party.

Upon termination of this agreement, no further claims may be submitted or paid by the Third Party Administrator or any representative of the program.

(Print Name and Title)

(Date)

(Signature)

(Organization)

(Complete Address with Zip Code)

(Telephone Number)

(Fax Number)

Signed: _____

Jill Ballard, Financial Manager
Division of Management Services
Idaho Department of Health and Welfare

(Date)

Standards Of Care



Minimum Expected Follow-up*: Breast or Cervical

- ✓ Whenever there is an *abnormal*, suspicious for cancer test result, a diagnostic work-up **MUST** be planned and recorded.
 - All clients with *abnormal* findings receive a definitive diagnosis.
 - All *abnormal* findings are resolved and reported.
- ✓ The time between the dates of the *abnormal* test result to final diagnosis **MUST** be no more than 60 days.
 - All diagnostic workups are resolved and reported.
- ✓ The time between the date of diagnosis and initiation of treatment **MUST** be no more than 60 days.
 - All clients needing treatment are referred.
- ✓ In the case of unsatisfactory results, the test must be **repeated** and the results reported to *Women's Health Check*.

CLINICAL BREAST EXAM/MAMMOGRAPHY

Results	Expected Follow-up:		
CBE	Mammogram	Diagnostic Procedures	Comments
Normal	<ul style="list-style-type: none"> Negative BI-RAD1 Benign BI-RAD2 Probably Benign BI-RAD3 	<ul style="list-style-type: none"> No work-up needed, therefore adequacy need not be assessed. Short term follow-up may be recommended. 	
Normal	<ul style="list-style-type: none"> Suspicious Abnormality BI-RAD4 	<ul style="list-style-type: none"> Repeat CBE Ultrasound Biopsy / lumpectomy or Fine needle aspiration 	<ul style="list-style-type: none"> Record final diagnosis
Normal or Abnormal	<ul style="list-style-type: none"> Highly Suggestive or Malignancy BI-RAD5 	<ul style="list-style-type: none"> Biopsy / lumpectomy or Fine needle aspiration 	<ul style="list-style-type: none"> Record final diagnosis
Normal	<ul style="list-style-type: none"> Assessment incomplete BI-RAD 0 	<ul style="list-style-type: none"> Additional mammography views or Ultrasound 	<ul style="list-style-type: none"> Record final diagnosis
Abnormal, Suspicious for Cancer	<ul style="list-style-type: none"> Negative BI-RAD1 	At least one of the following: <ul style="list-style-type: none"> Surgical Consult/Repeat CBE Ultrasound Biopsy / lumpectomy Fine needle aspiration 	<ul style="list-style-type: none"> Repeat mammogram or additional views not adequate; record final diagnosis
Abnormal, Suspicious for Cancer	<ul style="list-style-type: none"> Benign BI-RAD2 Probably Benign BI-RAD3 Assessment Incomplete Benign BI-RAD0 	At least one of the following: <ul style="list-style-type: none"> Surgical Consult/Repeat CBE Ultrasound Biopsy / lumpectomy Fine needle aspiration 	<ul style="list-style-type: none"> Record final diagnosis
Abnormal, Suspicious for Cancer	<ul style="list-style-type: none"> Suspicious Abnormality BI-RAD4 Highly Suggestive of Malignancy BI-RAD5 	<ul style="list-style-type: none"> Biopsy or lumpectomy Fine needle aspiration 	<ul style="list-style-type: none"> Record final diagnosis

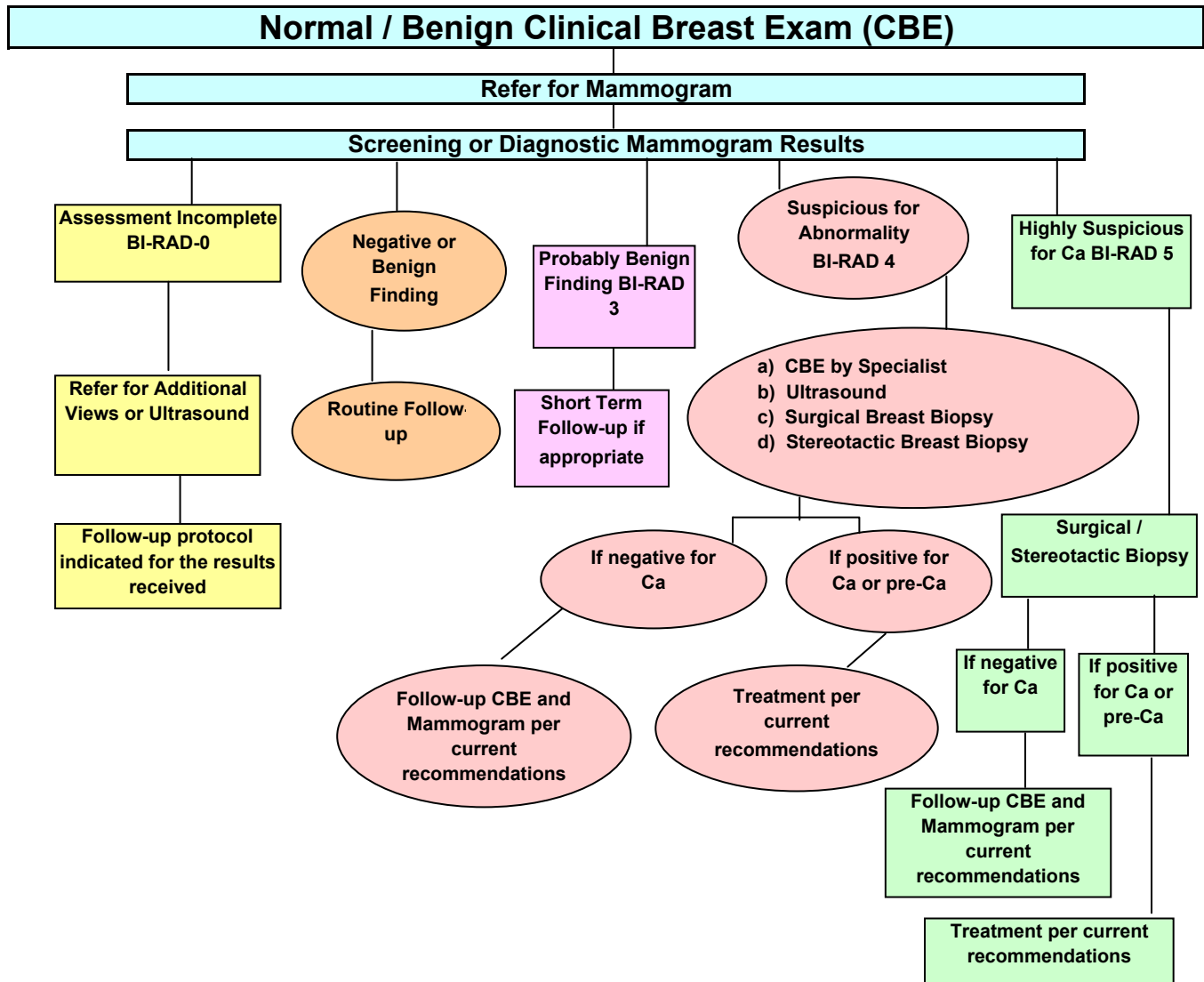
PAP TEST

Results	Expected Follow-up:	
Negative	Repeat Pap in <ul style="list-style-type: none"> 12 months if conventional, until 3 normal, then every 3 years 24 months if liquid based, until 3 normal, then every 3 years 	
Unsatisfactory	Repeat as soon as practical, treat infection if present	
ASC-US	If no work-up planned: If HPV positive, work-up required:	Repeat Pap in 6 months x2, consider HPV Colposcopy & Biopsy
LSIL	If no work-up planned: If work-up planned:	Repeat Pap in 6 months x2 Colposcopy & Biopsy
ASC-H HSIL AGC Squamous carcinoma AIS Adenocarcinoma	Work-up Required:	Colposcopy & Biopsy, ECC if indicated

*This algorithm is not a tool for clinical decision making for individual women, nor to dictate individual provider practice. It is a guide to use. Additional algorithms can be found in the Women's Health Check eManual www.healthandwelfare.idaho.gov under Women's Health.

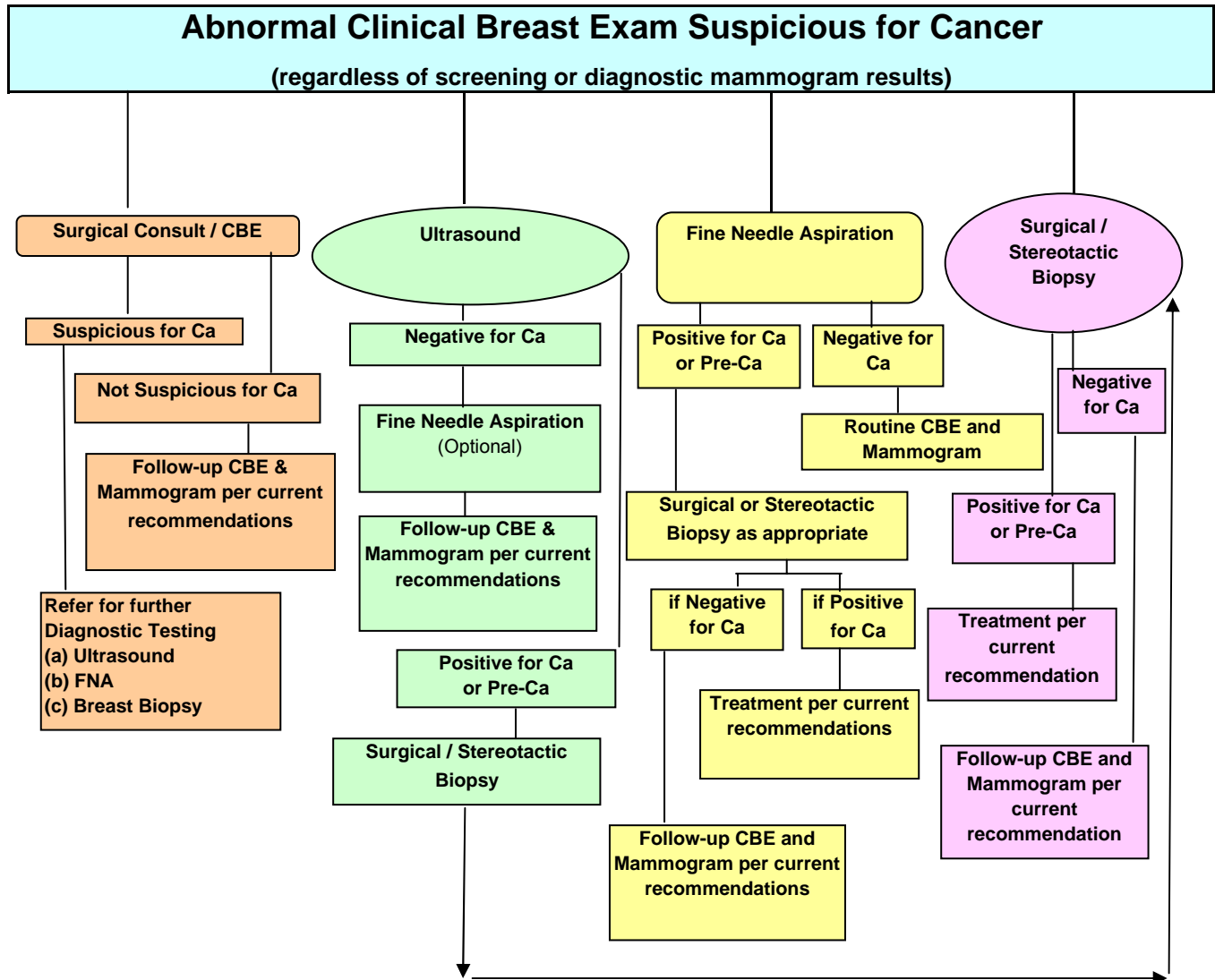


IDAHO WOMEN'S HEALTH CHECK
Standards of Care for Breast Cancer Screening - Algorithm 1



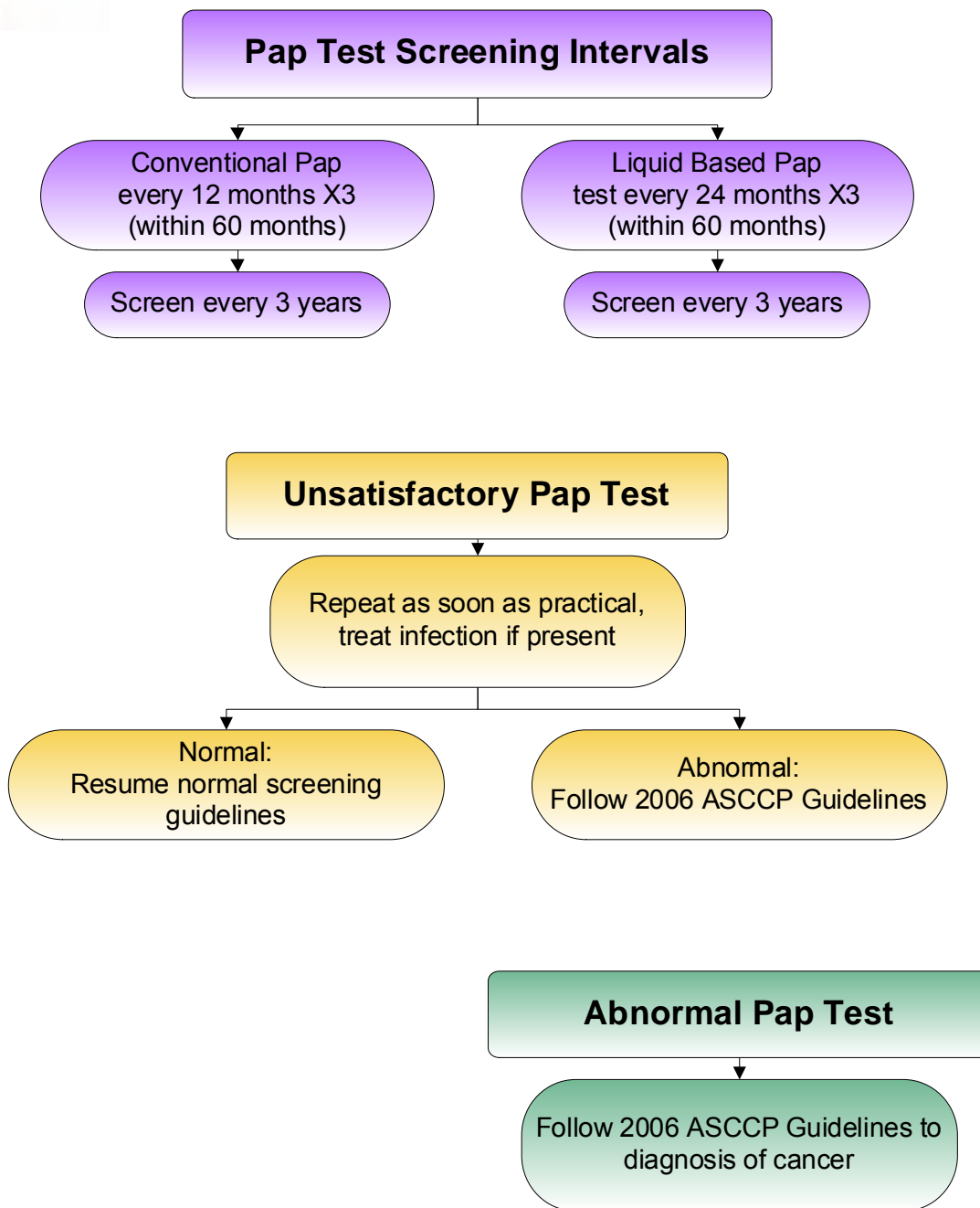


IDAHO WOMEN'S HEALTH CHECK
Standards of Care for Breast Cancer Screening - Algorithm 2





IDAHO WOMEN'S HEALTH CHECK
Standards of Care for Cervical Cancer Screening-Algorithm



Cancer Screening and Diagnosis

ANNUAL SCREENING APPOINTMENT

The annual appointment ensures regular screening for breast and cervical cancer. Each year clients must complete a new [Enrollment Form](#) verifying current eligibility (income, insurance, age). Local staff initial form to verifying eligibility after asking [key eligibility questions](#). Client provides contact name and number, indicates race/ethnicity and signs consent. If client is younger than priority screening age and has received normal diagnostic test or exam results, she may be determined inactive until priority screening age is reached.

Clinical breast exam (CBE) and Pap should be performed at the same visit. If prior screening services were provided at different times, schedule next services based on when next mammogram or CBE are due and delay pap until annual office visit unless client has developed symptoms associated with breast or cervical cancer.

ANNUAL SCREENING APPOINTMENT

- Determine client's eligibility using *WHC* [Enrollment Form](#).
- Review client's *WHC* responsibility and agreement to keep screening and follow-up appointments. ([Intake Assessment Form](#)) Question client about possible barriers to getting the mammogram or other services (beliefs, fear, transportation, childcare etc.).
- Obtain a second contact phone number if not on [Enrollment Form](#).
- Assist client with overcoming any identified barriers.
- Provide appropriate education. (Importance of Clinical Breast Exam (CBE) together with mammogram for early detection, size of lump found by CBE alone vs. mammogram and CBE, radiation exposure no more than dental x rays, exposed to more radiation flying coast to coast etc.)
- Make client appointment for mammogram or other services.
- Document in client record.
- Enter data in *WHC* Real Time data system (WHCRT).

ANNUAL RE-SCREENING PROTOCOL

Re-screening: The process of returning for a regular breast or cervical cancer screening test. After 3 consecutive normal Paps, the interval for cervical re-screening is every 3 years (women over age 30). If client is younger than priority screening age and has received normal diagnostic test or exam results, she may be determined inactive until priority screening age is reached. A clinical breast exam and a mammogram should be provided annually (women over age 50).

In order for a woman to be eligible for re-screening, she must meet all eligibility guidelines (each year). Each enrollment site has "Welcome Back" packets available which contain the appropriate forms to determine eligibility. The *Women's Health Check (WHC)* Enrollment Form must be completed, signed and submitted to the program annually. Beginning January 2008, the State Office will mail re-screen reminders to eligible clients 1 to 2 months prior to next screening date. A list of notified clients will be provided to each Local Coordinating Contractor (LCC) from State Office. The LCC continues to be responsible to any other patient reminders, such as short-term follow up.

- Scheduling clients for re-screening for breast and cervical cancer is the responsibility of all providers. Providers may use a computerized or manual system for this activity.
- State Office shall notify all clients in advance of the recommended re-screening dates. If no appointment is made after the first notification, a second attempt shall be made by LCC. Documentation of the notifications shall be retained in the client record.
- *Women's Health Check* LCCs are required to use *WHCRT* for data entry tracking and follow-up.

Note: CBE and Pap should be performed at the same office visit. If there were prior screening services at different times, schedule according to when next mammogram or CBE are due and delay Pap until next annual office visit, unless at high risk. Funds provide for one office visit for CBE and pap. Clients who have had CBE, mammogram, and pap at different times need to have these services coordinated when re-screened.

REQUIRED SCREENING SERVICES - BREAST

Women's Health Check (WHC) provides annual breast cancer screening for women of priority age.

Note: According to federal law, men are not eligible for WHC. Although a small percentage of men may develop breast cancer, the funding for this program is intended for screening the population at increased risk of breast and cervical cancer. Population based screening for men is not recommended.

The following services are required for a complete screening:

WHC BREAST CANCER SCREENING

Priority Population:

Qualifying women aged 50 - 64 are eligible for:

- Annual clinical breast examination (CBE) and mammogram for a complete screening.
- Diagnostic tests or Consultation by Breast Specialist as listed in WHC schedule of eligible [CPT codes](#), if needed.

Limited enrollment based on funding is available for qualifying uninsured women age 30 - 49 for:

- Clinical breast examination (CBE) if determined medically necessary due to abnormal test or exam results.
- Mammogram if determined medically necessary due to abnormal test or exam results.
- Diagnostic tests or Consultation by Breast Specialist as listed in WHC schedule of eligible [CPT codes](#), if needed.

[Limited Enrollment Approval Form](#) must be completed and submitted to LCC.

Note: Due to *WHC* funding, Clinical Breast Exam, pelvic and Pap test should be done at the same visit.

WHC encourages women to have complete screening for both breast and cervical cancer; however, women can be in the program for just breast or cervical cancer screening. Women under age 50 must meet enrollment criteria for each segment (breast or cervical) separately and may not receive annual tests if diagnostic test or exam results are normal.

PRIOR ENROLLMENT:

In some sections of the state, coverage areas of LCC's overlap and clients may move from one LCC area to another.

- Search for client in WHC Real Time data system. If the client has been previously enrolled with another LCC, it is the responsibility of the LCC determining eligibility to request a transfer before scheduling client appointments.

Note: Completed and signed Enrollment Form must be submitted to LCC within 24 hours. The LCC shall enter enrollment information into the WHC Real Time data system within 1 week of services provided.

REQUIRED SCREENING SERVICES - CERVICAL

Women's Health Check (WHC) provides annual cervical cancer screening for women of priority age.

The following services are required for a complete screening:

WHC CERVICAL CANCER SCREENING

Priority Population:

Qualifying women (with an intact cervix) aged 40 – 64, especially those who have not had a Pap test in the past 5 or more years, are eligible for:

- Conventional Pap and pelvic examination yearly for 3 consecutive normal Paps; then every 3 years.
- Liquid Based Pap and pelvic examination every 2 years until 3 consecutive normals; then every 3 years.

Limited enrollment based on funding is available for qualifying uninsured women ages 30 – 39 for:

- Pap test and pelvic until three normal Pap tests are documented.
- Diagnostic services if initial cervical cancer screening (Pap test) is abnormal (done at a participating *WHC* provider).
- Limited Enrollment Approval Form must be completed and submitted to LCC.

Note: After three (3) consecutive normal Pap tests, reimbursement for a Pap test is every three (3) years (within 60 months).

Women who have had a Hysterectomy:

- Due to cervical cancer or neoplasia, continue to be eligible for regular cervical cancer screenings.
- Performed for any other reason will be eligible for one pelvic exam to confirm the presence or absence of the cervix. If there is no cervix, she is not eligible for cervical cancer screening.

Note: Due to *WHC* funding, Clinical Breast Exam, pelvic and collecting Pap specimen should be done at the same visit.

WHC encourages women to have complete screening for both breast and cervical cancer; however, women can be in the program for just breast or cervical cancer screening. Women under age 50 must meet enrollment criteria for each segment (breast or cervical) separately, and will not continue annual screening if diagnostic tests have normal results.

PRIOR ENROLLMENT:

In some sections of the state, coverage areas of LCC's overlap and clients may move from one LCC area to another.

- Search for client in WHC Real Time data system. If the client has been previously enrolled with another LCC, it is the responsibility of the LCC determining eligibility to request a transfer before scheduling client appointments.

Note: Completed and signed Enrollment Form must be submitted to LCC within 24 hours. The LCC shall enter enrollment information into the WHC Real Time data system within 1 week of services provided.

DIAGNOSTIC SERVICES

Women's Health Check provides for screening and diagnostic services. The following diagnostic tests, as listed in schedule of eligible [CPT codes](#) for this program are offered:

WHC DIAGNOSTIC SERVICES – BREAST

- Repeat CBE and/or mammogram
- Fine needle aspiration (FNA)
- Ultrasound
- Core needle biopsy
- Stereotactic breast biopsy
- Incisional and excisional biopsies
- Specialist consultation
- Anesthesia associated with biopsy

WHC DIAGNOSTIC SERVICES – CERVICAL

- Repeat Pap test and pelvic examination
- Colposcopy (with or without biopsy)
- Endocervical curettage (ECC) – colposcopy as directed
- Specialist Consultation
- HPV, Amplified Probe
- Endometrial Sampling
- Diagnostic LEEP, conization for definitive diagnosis – [Pre-approval from state WHC office required](#)

Services not listed in schedule of eligible [CPT codes](#) will not be reimbursed by WHC. The program does not cover blood tests, MRI, CT, Abdominal Ultrasound and other services that may be commonly prescribed.

Note: [Local Coordinating Contractor](#) (local Health District or contracting agency) will assist with case management and follow-up of clients with abnormal screening results or who have other major barriers to obtaining eligible services.

WHC PROGRAM CRITERIA FOR DIAGNOSTIC CONIZATION OR LEEP PROCEDURES:

Note: Requires pre-authorization on an individual client need basis. Contact the state WHC office. (Julie Orgill at 208-334-5971).

BACKGROUND

- Centers for Disease Control and Prevention issued a policy in June 2004, based on the proceedings of the American Society of Colposcopy and Cytopathology (ASCCP) Consensus Conference on Management of Abnormal Cervical Cytology Reports (2001).
- The policy allows for use of NBCCEDP (federal program) funds for loop electrode excision procedure (LEEP), laser conization, and cold-knife conization.

CRITERIA FOR WHC REIMBURSEMENT

- LEEP or cold-knife conization of the cervix may be reimbursed as a diagnostic procedure when colposcopy does not demonstrate a definitive diagnosis.
- See the [ASCCP recommendations](#) on management of women with high-grade intraepithelial lesions (HSIL) which must be followed.

SATISFACTORY COLPOSCOPY:

- When no lesion or only biopsy-confirmed CIN I is identified after satisfactory colposcopy in women with HSIL Pap test reports, it is recommended that a review of the colposcopy, Pap, and histology results be performed.
- If the review yields a revised interpretation, management should follow guidelines for the revised interpretation.
- If a cytological interpretation of HSIL is upheld, a diagnostic excisional procedure is preferred in non-pregnant patients.
- A colposcopic reevaluation with endocervical assessment is acceptable in special circumstances such as when CIN II or III is not found in a young woman of reproductive age or during pregnancy when invasive cancer is not suspected.

UNSATISFACTORY COLPOSCOPY:

- When no lesion is identified after unsatisfactory colposcopy in women with HSIL, a review of the cytology, colposcopy, and histology results should be performed when possible.
- If the review yields a revised interpretation, management should follow guidelines for the revised interpretation.

- If a cytological interpretation of HSIL is upheld, review is not possible, or biopsy-confirmed CIN I is identified, a diagnostic decisional procedure is recommended in non-pregnant patients.
- Ablation is unacceptable.
- During pregnancy, if initial colposcopy is unsatisfactory, it may become satisfactory later in pregnancy and so should be repeated within 6-12 weeks.
- Omission of endocervical sampling is acceptable when a diagnostic excisional procedure is planned.
- In women with HSIL in whom colposcopy suggests a high-grade lesion, initial evaluation using a diagnostic excisional procedure is also an acceptable option.
- Triage using either program of repeat cytological testing or HPV DNA testing is unacceptable.



Approval for Diagnostic LEEP or Conization*

Submit for Pre- Authorization. Attach copies of pertinent reports.

Request must be based on need for definitive diagnosis not demonstrated by colposcopy.

Client Name: _____ Age: _____ D.O.B. _____

☐ **Satisfactory Colposcopy**

☐ No lesion or only biopsy confirmed CIN I identified with HSIL Pap

☐ Colposcopy and histology reports reviewed (when possible), no new interpretation, HSIL upheld

Result and Date of prior cytology(Pap) _____

Result and Date of prior histology (biopsy) _____

☐ **Unsatisfactory Colposcopy**

☐ No lesion identified in client with HSIL Pap

☐ Colposcopy and histology reports reviewed - no new interpretation, HSIL upheld

Result and Date of prior cytology (Pap) _____

Result and Date of prior histology (biopsy) or ECC _____

☐ **Unexplained Atypical Glandular Cells – neoplastic or worse**

☐ Pap reviewed and AGC-neoplastic, ACIS, or adenocarcinoma confirmed

☐ Colposcopy, cervical biopsy if any, ECC, and EMB reviewed - no HSIL, ACIS, invasive carcinoma, endometrial hyperplasia, or endometrial cancer found

Result and Date of prior cytology (Pap) _____

Result and Date of prior histology (biopsy), if applicable _____

Result and Date of prior ECC _____

Result and Date of prior EMB _____

Comments: _____

☐ Based on information documented above, this client is at high risk and LEEP or Conization is recommended for definitive diagnosis.

Clinician: _____ Title: _____ Phone: _____ Date: _____

Contracting Clinic: _____

Local Case Manager:

Name _____

Title _____ Date _____

Approved by WHC State Office:

Name _____

Title _____ Date _____

CPT Codes for Reimbursement*:

57460 – colposcopy of the cervix with loop electrode biopsy(s) of the cervix

57461 – colposcopy with loop electrode conization of the cervix

57520 – conization of cervix, with or without fulguration, with or without dilation and curettage, with or without repair; cold knife or laser

57522 – loop electrode excision

58100 – Endometrial Sampling with or without Endocervical Sampling

00940 – Anesthesia Fees related to Approved Cervical Procedures

***THIS FORM MUST BE ATTACHED to CLAIM SUBMISSION for REIMBURSEMENT.**

Treatment

TREATMENT SERVICES

Only women who have been screened and diagnosed with breast or cervical cancer or neoplasia through Women's Health Check (*WHC*) may qualify for treatment through BCC Medicaid.

- The client must be under age 65, be a U.S. citizen or eligible alien, reside in Idaho and have no creditable insurance.
- The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA - the Act) (**Public Law 106-354**) provides treatment through Medicaid for women who have been screened and diagnosed with breast or cervical cancer through *Women's Health Check*.

Note: More information about BCC Medicaid and Treatment can be found under Case Management, [BCC-Medicaid](#).

Case Management

CASE MANAGEMENT

Case management is a system of assessment, planning, coordination, monitoring, evaluation, and resource development. Once a woman with an abnormal screening result is identified, she should be assessed for medical and social services needs as well as barriers impeding her access to diagnostic and/or treatment services.

In special instances, case management (CM) can be provided to women who have previous history of abnormal findings, screening which requires short-term follow-up, and/or do not respond to re-screening reminders.

GOAL

To ensure that women enrolled in the program receive timely and appropriate diagnostic, treatment, and re-screening services.

Note: There should be no more than 60 days between the time an abnormal finding is identified and final diagnosis. There should be no more than 60 days between diagnosis and initiation of treatment.

INTAKE ASSESSMENT FORM

- **Must be completed on all clients at the time of enrollment** to insure client understands and agrees to terms of participation in *Women's Health Check (WHC)* and to identify any client barriers to service. The [Intake Assessment form](#) should be maintained by local case manager in client file, with a copy given to client upon enrollment.
- Provides assessment of any barriers to obtaining and completing services.
- **Provides notice to client that non-covered services are not paid by the program.**
- Service Referral section provides location for additional services if enrolled at a site that does not provide comprehensive *WHC* services.
- *WHC* clients may be referred to qualified providers for additional breast and cervical screening / diagnosis services, as long as those providers have entered into a "Memorandum of Agreement" with the state.

CLOSURE

- Client should be closed to *WHC* when she is no longer eligible due to income, insurance, or becomes eligible for Medicare and secures Medicare Part B coverage (notify State *WHC* office).
- Client should be closed to *WHC* when she moves out of state (notify *WHC*).
- Case Management Services conclude when:
 - Diagnostic services have been completed, no cancer diagnosis.
 - Treatment is initiated (clients accepted by Medicaid for treatment should be maintained in the tracking system and notified when it is time for re-screening).

Note: All providers must be appropriately licensed, and have a contract or formal agreement with the state Women's Health Check program that outlines billing, reporting of results, and that client will not be billed for eligible services.

Clinical and Clerical Case Management

CASE MANAGEMENT

Case management is a system of assessment, planning, coordination, monitoring, evaluation, and resource development. Once a woman with an abnormal screening result is identified, she should be assessed for medical and social services needs as well as barriers impeding her access to diagnostic and/or treatment services.

In special instances, case management (CM) can be provided to women who have previous history of abnormal findings, screening which requires short-term follow-up, and/or do not respond to re-screening reminders.

CLINICAL- RN CASE MANAGER

- Review abnormal reports and direct diagnostic workups.
- Coordinate communications and services between providers, clients, and Women's Health Check program.
- Guide clerical staff with identified barriers on Intake Assessment form.
- Provide information and support to clients and clerical staff. Encourage the use of resource materials.
- Assist with arranging translation services for surgical consult appointments.
- Contact providers and clients with diagnosis of cancer or pre-cancer. Identify plan of care.
- Complete Presumptive Eligibility with client.
 - Provide information on Medicaid and Estate Recovery. Refer the client for additional questions if needed.
 - Inform the client that a Medicaid Nurse will contact her within a few days to assist her with her medical care.
 - Include biopsy report and other pertinent documents.
 - Include insurance information and citizenship information if applicable.
 - Forward to state WHC office.
- Review Quality Assurance reports and Client Alert list and address case management issues on a weekly basis.

Note: There should be no more than 60 days between the time an abnormal finding is identified and final diagnosis. There should be no more than 60 days between diagnosis and initiation of treatment.

CLERICAL CASE MANAGEMENT RESPONSIBILITIES

ENTER DATA ON NEWLY ENROLLED AND RETURNING CLIENTS IN WHC REAL TIME SYSTEM (WHCRT)

- Enter same day or as soon as possible within one week of service or receipt of result.
- Determine any barriers checked on [Intake Assessment](#) form and follow local protocol to address.
- Include Pap and mammogram history.
- Submit signed and completed enrollment forms for new and returning clients to State WHC with monthly billing.
- Enter screening, diagnostic, Short Term Follow-up (STFU) results as soon as received.
- Complete cycles, treatment start dates.
- Print and monitor [Quality Assurance Reports](#).
- Determine reasons for missing/incomplete information – document in comment section of cycle (appointments not kept, reports not sent etc.).
- Submit Enrollment Service Monthly Checklist to State WHC office.

MONTHLY PRIORITIES:

- Run reports for STFU due – make appointments and document patient contact in WHCRT comments section.
- Make appointments and document patient contact in WHCRT comment sections for annual re-screen due sent from the WHC state office.
- Run and review WHCRT reports for missing, incomplete data.
- Enter missing, incomplete data.
- Document reason for missing/incomplete data and action taken, especially abnormal work ups using comments section on client demographics or cycle screens of WHCRT.

CLERICAL/CLINICAL CASE MANAGEMENT RESPONSIBILITIES

- Review [Abnormal Reports](#) with RN.
- Take appropriate action – determine reason for appointments not kept, reschedule and document in comments section of WHCRT. Obtain reports.
- Refer problems to RN when appropriate (fear, denial, refusal etc.).
- Refer clients with multiple diagnostic procedures, biopsies to RN.
- Ensure client access to resource/education materials.
- Refer clients with diagnosis of cancer to RN for case management and Medicaid Application or other treatment referral.

CYCLE COMPLETION

Cycles are used by *WHC* to identify an appropriate end to the screening process. Most cycles are simple – screening, normal result, close cycle and notify client next year when she is due for re-screening. Abnormal screening results create more complex cycles. Cycles relate to data entry into the *WHC* Real Time system.

NORMAL RESULT

- Screening cycle begins with data on Pap smear, mammogram or Clinical Breast Exam (CBE).
- Ends with normal screening results and completed data entered into client record and *WHC* Real Time system.

ABNORMAL FINDINGS

- Screening cycle begins with data on Pap smear, mammogram or CBE.
- Diagnostic procedures and diagnosis reached, treatment started if appropriate.
- Data collected, recorded on appropriate forms and entered into *WHC* Real Time system.
- Abnormal findings, cycle does not end until diagnosis and treatment data are complete.
- Cancer not found, but follow-up needed at a later time (this is recorded as a shorter interval than re-screening).
- Planned delay for short term follow-up/re-screen starts a new cycle.

INCOMPLETE SERVICES

- Unable to complete cycle because client moved out of area, unable to locate client or client refused services.
- Data collected, forms completed, written documentation of attempts to complete services/locate client, data entered, submitted to *WHC*.
- Inability to complete services after three attempts closes cycle. If cycle involves abnormal results, the final attempt shall include a [certified letter](#) to the client that identifies risks of failure to follow-up.

RE-SCREENING REMINDER SYSTEM

The *Women's Health Check Real Time (WHCRT)* system is designed to collect required data that must be reported to CDC, while also providing essential quality assurance reports to ensure appropriate and timely follow-up.

- To ensure claims payment, enrollment sites shall fax and mail client **enrollment** form and client **intake assessment** form to Local Coordinating Contractor (LCC) as soon as **enrollment** form is signed and client is determined to be **eligible** according to age, income, and insurance.
- **LCC** is responsible for entering accurate and complete client data within one (1) week of receiving this information.

QUALITY ASSURANCE REPORTS

ABNORMAL REPORTS:

Abnormal Mamms/CBE with No Follow-up and **Abnormal Paps with No Follow-up** must be reviewed weekly.

- Identifies patients with an abnormal CBE/mammogram or Pap result
 - with no diagnostic result or
 - no date of a completed diagnostic follow up procedure and no final diagnosis recorded.

Shot Term Follow-up Due must be reviewed at least monthly.

- Identifies patients recommended for return in less than 12 months
 - indicates number of months before return appointment
 - calculated from the performed date of a previous procedure with this recommendation
 - this date must fall within the dates set for return.

SCREENING/SCHEDULING REPORTS:

These specific and general reports are supplemental 'case management' reports to help ensure that screening cycles are complete and timely and should be run on a periodic basis (weekly is suggested). Patients with these circumstances do not appear in the 'ALERTS' in the *WHC Real Time* data system.

- **CBEs Without Mamms:** Identifies patients who had a CBE performed within the date range of the report and no Mammogram result entered.
- **Mamms Without CBEs:** Identifies patients who had a mammogram performed within the date range of the report and no CBE result has been entered
- **Pelvic Exams Without Paps:** Identifies patients who had a pelvic exam performed within the date range of the report and no pap result has been entered
- **Missed Appointments/Missing Results:** Identifies patients who have appointment dates entered for any service.
 - Appointments 14 days past date scheduled with no performed date or result entered
 - Either the patient did not keep the appointment or the provider has not forwarded the results.
- **Appointments Scheduled:** Identifies future patient appointment dates. Enables you to run a report of appointments to occur in the future for all providers, or individual provider/clinicians

LCC ADMINISTRATION:

These reports are primarily for the administration of the Women's Health Check program. They are tools that you can use to meet Women's Health Check requirements.

- **Enrollment Services Monthly Checklist:** MUST accompany your monthly enrollment forms.
- The total at the end of the report is the number of unique patients that had services in the month you are billing for.
- Counts patients only once for a screening year in the month that their first service is recorded.
- Enrollment forms and Limited Enrollment Approval forms should be arranged alphabetically, checked off and sent with this report to the WHC state office.
- **Patients in Treatment:** Identifies LCC patients who are currently on Medicaid for treatment of breast or cervical cancer.
- Recommend running periodically (at least monthly), to determine who is due for annual screening.
- Recommend personal contact to setup their screening. The patients on this list will not be on the Reminder Mail Merge File.

Note: Clients younger than priority screening age (<50 breast; <40 cervical) who have normal screening/diagnostic tests should be re-screened when reaching priority age.

INCOMPLETE SCREENING SERVICES

CDC requires complete screening. This means a Clinical Breast Exam (CBE) and mammogram for breast screening, and a pelvic exam and Pap for cervical screening. All results must be recorded in *Women's Health Check Real Time (WHCRT)* system before the screening is considered complete. The Local Coordinating Contractor (LCC) is responsible for complete screening services.

Health Care Professionals and the LCC **must** work cooperatively to ensure timely and adequate services are provided to *WHC* clients.

EXAMPLES OF INCOMPLETE SCREENING:

- CBE with no mammogram or other incomplete screening or re-screening.
- Mammogram with no CBE.
- Abnormal CBE or mammogram with no follow-up results recorded.

ACTIONS TO ENSURE COMPLETE SCREENING SERVICES

CLERICAL RESPONSIBILITIES:

- Identify missed appointments **within two (2) weeks**. Use *WHCRT* reports to simplify this process.
- Contact client to determine reason for missed appointment. Document response in *WHCRT*.
- Assist with overcoming barriers. Refer to [Intake Assessment](#) form and discuss transportation, language, family care, social stigma, fears and attempt to resolve identified barrier(s). This is part of [case management](#).
- **Reschedule appointment so that interval between CBE and mammogram is <60 days.**
- If appointment not kept, or client refuses, document and close **OR** inform client that you will not contact her again until next year when she is due for annual re-screening. She is welcome to call for an appointment if she changes her mind.
- Document appointment (date, date of service and final result) in client record and *WHCRT*.

CLINICAL RESPONSIBILITIES:

- Identify need for medical interpretation for a client who is not fluent in English language when referred to a surgeon. Arrange for appropriate [medical interpretation resources](#).

FOLLOW-UP OF ABNORMAL FINDINGS

The most common source of malpractice litigation in the field of oncology and the second most common source of medical malpractice litigation overall (after obstetrical and birth injuries) are claims of failure to make a timely diagnosis of breast cancer. (Breast Cancer Study, Physician Insurers Association of America, Rockville, MD. June 1995.)

Note: The time from abnormal finding to final diagnosis should be no more than 60 days.

CLERICAL RESPONSIBILITIES:

- Identify appointments not kept **within one week**. Use *WHC* Real Time system to enter appointments made and review Missing Appointment/Missing Results report weekly.
- Contact client to determine reason for missed appointment.
- Assist with overcoming barriers. Refer to RN for case management if appropriate (fear of procedure, denial, etc.).
- **Reschedule appointment so the time from abnormal finding to diagnosis is ≤60 days.**
- If appointment not kept, make 3 attempts to contact (last attempt – certified letter).
- Include recommendations, review of client's responsibility, refusal form to be signed by client and returned, stamped return envelope and notice of opportunity to re-consider follow-up.
- If client verbally refuses, send [certified letter](#).
- Document in client record, *WHC* Real Time system. **Close if no response.**
- Close [cycle](#) promptly when:
 - All screening/diagnostic results are negative, return in one year
 - Short Term Follow-Up (STFU) scheduled (planned delay)
 - Diagnostic workup complete, cancer diagnosis
- Assist RN/Case Manager with [BCC Medicaid](#) application, if applicable.
- Enter final diagnosis and treatment start date in *WHC* Real Time system.

CLINICAL RESPONSIBILITIES

- An abnormal Clinical Breast Exam (CBE), even with a normal mammogram, requires diagnostic follow-up. See [Standards of Care](#) algorithms.
- Identify appropriate diagnostic referrals needed. See [Standards of Care](#) algorithms.
- Review abnormal reports weekly and identify measures needed to obtain timely diagnosis and treatment.
- Identify barriers needing clinical case management (fear of procedure, denial, refusal, etc.).

LOST TO FOLLOW-UP

When a Local Coordinating Contractor ([LCC](#)) is not able to contact the client via telephone or mail, client record will be closed indicating client is lost to follow-up.

ROUTINE LOST TO FOLLOW-UP (NO UNRESOLVED ABNORMAL RESULTS)

- Document in client record and *WHC* Real Time system attempt to contact failed.
- Close client record after two attempts. Document in cycle comment section that client is lost to follow-up.

ABNORMAL TEST RESULTS/HIGH RISK FOR CANCER

- Make three attempts to contact - by letter and phone call. A certified letter must be the last attempt to contact a client with any **abnormal** findings.
- Document in cycle comment section in *WHC* Real Time system that client is lost to follow-up. **Close if no response.**

SHORT TERM FOLLOW-UP

When screening or diagnostic results indicate that a client should return sooner than her annual appointment but not needing diagnostic work-up at this time, it is tracked as Short Term Follow-Up (STFU).

- **By entering date, WHC Real Time system can generate STFU report which should be utilized to schedule STFU appointments.**
- Scheduling STFU is the responsibility of the case manager.
- Contact client with a written reminder or telephone call.
- If client verbally refuses, send registered/certified letter.
- Include recommendations, review of client's responsibility, refusal form to be signed by client and returned, stamped return envelope and notice of opportunity to re-consider follow-up.
- Document in client record, *WHC* Real Time system. **Close if no response.**

Note: For more information related to Short Term Follow-up, see the WHC Real Time User Manual.

REQUESTING TRANSLATION SERVICES

Women's Health Check is able to reimburse for translation services for non-English speaking clients that require surgical consult visits.

- The local coordinating contractor (LCC) will set up translation services between client, surgeon, and translator.
- LCC will complete Request for Medical Translation form.
- LCC will fax complete translation request to translator.
- Translator will provide services, and complete billing portion of Request for Medical Translation form.
- Translator will fax translation request to WHC State Office for reimbursement of services.

Note: For additional information, contact state office: 208-334-5805.



Request for Medical Translation

Submit to WHC state office at address below.

Client Name: _____ Age: _____ D.O.B. _____

Native language _____ Telephone _____

Date of Appointment _____ Time _____ Location: _____

Directions: _____

Reason for appointment: _____

Additional comments: _____

Person requesting translation services: _____

Translator: _____ Phone: _____

To ensure payment, submit this request* for reimbursement within 30 days to:

**WOMEN'S HEALTH CHECK
450 W STATE ST 4TH FL
PO BOX 83720
BOISE ID 83720-0036**

*Include W-9 form if not previously submitted

of hour(s) _____ @ _____ per hour Total amount billed: _____

Send payment to:

Name: _____

Address: _____

Quality Assurance and Quality Improvement

REQUIRED DATA¹

The collection, analysis, and use of quality data are essential for guiding program efforts. To meet Centers for Disease Control and Prevention's data management expectations, a grantee is required to:

- Establish and maintain a data system for collecting, editing, and managing the data needed to track a woman's receipt of screening, rescreening, diagnostic, and treatment services.
- Establish mechanisms for reviewing and assessing the completeness, accuracy, and timeliness of data collected.
- Establish protocols to ensure the security and confidentiality of all data collected.
- Collaborate with other existing systems to collect and analyze population-based information on breast and cervical cancer, including incidence and mortality rates, cancer stage at diagnosis, and the demographic profile of cancer patients.

NBCCEDP RESEARCH AND EVALUATION

The data collected by the NBCCEDP facilitate the identification, analysis, and resolution of important issues in the provision of breast and cervical cancer screening to underserved women. Each grantee submits to CDC minimum data elements (MDEs) that are useful for planning and evaluation functions and as a basis for scientific studies. Researchers have used MDEs to examine such issues as how frequently Pap tests are needed once a series of tests are reported as negative, differences in screening mammography between the United States and the United Kingdom, and racial and ethnic differences in screening outcomes. Additionally, analysis of NBCCEDP data has been valuable in determining that linkage of the MDEs with [state cancer registries](#) is important in consistently and accurately reporting cancer-stage data. This has led to greater cooperation between units in the health departments and from the community at large.

Of equal importance is the contribution of the MDE data set to public health practice. Designed to monitor the extent to which funded programs in the NBCCEDP achieve the objectives of the authorizing legislation, the MDEs provide demographic, service, and outcome data that have had a dramatic impact on policy and program development. For example,

Descriptive reports of MDE data allow CDC to quickly identify programs struggling to meet clinical or service standards set for the national program and provide technical assistance before quality declines. These reports also guide the development of training for grantees and contribute to the identification of best practices for dissemination.

Monitoring the MDEs may result in the identification of common deficiencies that suggest that system-wide changes are needed. New national policies or partnerships may result. An example is the relationship CDC has developed with the Migrant Clinicians' Network to enhance the cancer-related case management of migrant, homeless, and mobile people.

Quality assurance (QA) is a major outcome of effective use of MDEs. Grantees can evaluate the work of individual providers against a standard and identify outliers for whom QA interventions may be needed. The MDE system provides essential information on the timeliness, adequacy, and appropriateness of follow-up of clinical care ensuring that problems are addressed and changes made.

Outcomes of MDE reporting activities have resulted in significantly increased funding, allowing additional women to be screened nationwide for breast and cervical cancer. In addition, MDE data are useful in evaluating and influencing the development of updated national cancer screening recommendations and guidelines, tracking cancer rates among women who are never or rarely screened, testing the efficacy of screening technologies, and developing models to address other cancers. Data from the NBCCEDP support performance-based budgeting and the effective stewardship of taxpayers' dollars and public trust.

Data about who is being served, with what services, within what time frame, and with what results allow CDC and its partners to assure the public that the NBCCEDP provides high-quality services to eligible women and contributes significantly to the reduction of the breast and cervical cancer burden in the country.

¹Centers for Disease Control and Prevention. [*The National Breast and Cervical Cancer Early Detection Program 1991–2002 National Report*](#). Atlanta (GA): Department of Health and Human Services; 2005.

BCC Medicaid

BCC MEDICAID TREATMENT SERVICES

Only women who have been screened and diagnosed with breast or cervical cancer or neoplasia through Women's Health Check (WHC) may qualify for treatment through BCC Medicaid.

- The client must be under age 65, be a U.S. citizen or eligible alien, reside in Idaho and have no creditable insurance.
- The Breast and Cervical Cancer Prevention and Treatment Act of 2000 (BCCPTA - the Act) (**Public Law 106-354**) provides treatment through Medicaid for women who have been screened and diagnosed with breast or cervical cancer through *Women's Health Check*.

Note: It is the responsibility of the Local Coordinating Contractor (LCC) Case Manager to counsel clients who are not eligible for BCC Medicaid regarding other resources.

RESPONSIBILITIES FOR LCC CASE MANAGERS:

- Obtain documentation of diagnosis (pathology report).
- Obtain initial treatment plan (i.e. appointment with surgeon, oncologist, radiologist).
- Schedule appointment with client:
 - Complete forms with client
 - Presumptive Eligibility (PE) Form
 - Inform client about Medicaid and Estate Recovery.
 - Obtain insurance information (if applicable).
 - Obtain Alien ID number if non-citizen.
 - Provide diagnostic education materials and opportunity for questions. Identify any barriers to following thru with treatment plan.
 - Ensure that client understands diagnosis and treatment plan and has access to resources.
 - Submit (fax, scan or e-mail) complete application **immediately** to WHC State Office:
 - FAX ([cover sheet](#) and forms) to 208-334-0657
 - E-mail to: orgillj@dhw.idaho.gov or slaughtl@dhw.idaho.gov

Note: It is a high priority to request and obtain final diagnosis within a week and submit completed BCC Medicaid application IMMEDIATELY.

Estate Recovery

When you get Medicaid benefits and are over 55, you can't give your property away to others.

After you and your spouse pass away, your money and property will be used to repay Medicaid.

Under certain conditions, your children can request a Hardship Waiver.

For more information, call the Medicaid Recovery Office at: (866) 849-3843, or Call the Idaho CareLine (2-1-1) and ask for a copy of Property Liens and Estate Recovery #HW-0474.

**State of Idaho
Department of Health and Welfare**

PROPERTY LIENS AND ESTATE RECOVERY

ESTATE RECOVERY

The Department of Health and Welfare (DHW) may recover the costs of Medicaid benefits from your estate after you and your spouse have passed away. State law restricts transfers of property by Medicaid recipients or their spouses to others. Idaho Code §56-218(1).

LIENS

Liens may be filed to protect DHW's ability to recover Medicaid costs if property is sold or transferred by a Medicaid recipient or by a spouse. No lien is filed while the Medicaid client lives on the property. Even though a lien is filed, your children may continue to live there under certain circumstances (see Hardship Waivers). No liens are filed on Tribal Trust land. State law gives DHW authority to file two types of liens, both of which are filed/recorded at the office of the Secretary of State.

Nursing Facility Lien:

DHW may file a lien, after giving notice and an opportunity for a hearing, against your real property if you are a **long term** resident of a nursing facility, or intermediate care facility for the mentally retarded at any age. 42 USC §1396p(a); Idaho Code §56-218A. If you are discharged and return to your home, the lien is released.

Estate Recovery Lien:

DHW may file a lien against any of your real and personal property, including cash, **after your death**, if you received Medicaid services after age 55. Idaho Code §56-218(6).

PROPERTY TRANSFERS

Medicaid recipients and their spouses may not transfer property for less than fair market value, except to each other,. If your property is transferred for less than fair market value, to someone other than a spouse, DHW can petition the court to set aside the transfer. Fair Market Value is defined in IDAPA 16.03.05.005.11 as the, "[p]rice for which the asset can be reasonably expected to sell on the open market, in the geographic area involved."

RECOVERY OF COSTS

In addition to costs for your care, DHW will seek to recover Medicaid payments for Medicare premiums, co-insurance, and deductibles, including those paid on behalf of a person who is a Qualified Medicare Beneficiary (QMB), or a Specified Low-Income Medicare Beneficiary (SLMB), DHW will not demand payment:

- For services received before July 1, 1988, by those age 65 and older;
- For services received before July 1, 1994, by those between age 55 and 65;
- For services needed due to a crime;
- While a surviving spouse resides in the home;
- Before a surviving child reaches age 21;
- If you have a child that is blind or permanently disabled.

When a Medicaid client dies, no cash, real property or personal property should be distributed before the Medicaid Estate Recovery Officer is notified. The Medicaid Estate Recovery Office is located at:

Medicaid Estate Recovery
P.O. Box 83720
Boise, ID 83720-0036
1-866-849-3843

PROBATE

DHW has a claim for recovery of all paid Medicaid benefits. The claim is statutory (Idaho Code §56-218), and has priority under the Probate Code. This claim is made against all assets in which the Medicaid client had an interest as of the date of death. All assets means real and personal property including bank accounts, annuities, sales contracts and other assets conveyed to a survivor, through joint tenancy, tenancy in common, survivorship, life estate, living trust or other arrangement. Idaho Code § 56-218(4). A Personal Representative should be appointed by the court if the estate includes real property and in some other cases. When a Personal Representative is appointed, the Director of Health and Welfare must be notified within 30 days. When distributing estate funds, the Personal Representative may pay burial expenses and administrative costs first and is not obligated to pay expenses from his personal funds.

MARRIAGE SETTLEMENT AGREEMENT

DHW's statutory claim is made against the estates of both spouses, even when a marriage settlement agreement or other agreement is used to separate property for Medicaid eligibility. No claim is made against the separate property of the Medicaid recipient's spouse when that property has always been maintained as separate property.

REQUEST FOR HARDSHIP WAIVER

DHW may waive its claim, in whole or in part, if DHW determines that certain specific hardship conditions are met. Hardship waivers must be requested within 90 days of the date of death, or within 30 days following notice of the Department's claim. **The fact that family members anticipate or expect the inheritance is not cause for DHW to grant a hardship waiver.** A beneficiary of the estate may request DHW to consider a hardship waiver by writing to the Estate Recovery Officer at the above address in Boise. Conditions for a hardship waiver include the following:

- The estate subject to recovery is income producing property that provides the primary source of support for other family members; or
- The estate has a value below \$500, excluding bank accounts which are not eligible for waiver under this criteria; or
- Recovery by DHW would cause the heirs of the deceased individual to be eligible for public assistance.

You may request an appeal hearing if you believe the Department has incorrectly denied a hardship waiver request.

If you have any further questions, please contact the Medicaid Estate Recovery Office at 1-866-849-3843.

BCC-MEDICAID APPLICATION – INSTRUCTIONS

It is the responsibility of the Local Coordinating Contractor (LCC) Case Manager to facilitate the BCC-Medicaid Application process.

- The client must be under age 65, be a U.S. citizen or eligible alien, reside in Idaho and have no creditable insurance.

INSTRUCTIONS FOR LCC CASE MANAGERS TO COMPLETE BCC-MEDICAID APPLICATION:

1. Submit:

- Presumptive Eligibility (PE) Form, Idaho – Medicaid
 - LCC Case Manager completes and signs
 - Obtain Initial Plan of Care and Treatment Start Date from the diagnosing physician or surgeon / specialist
 - Print physician(s) name(s) and telephone number(s) to be legible
- If insured, copy of insurance card front and back
- If non-citizen, copy of alien ID card

Note: It is the responsibility of the LCC Case Manager to complete the Presumptive Eligibility form.

2. Submit above required forms along with following Women's Health Check (WHC) forms to WHC State Office Via Confidential FAX 208.334.0657. Use [cover sheet check list](#).

- Idaho WHC Enrollment Form – signed by client
- Tests performed, dates, and results. Include reports from diagnostic services (i.e., pathology, surgical consult, radiology).

Note: Make sure information is complete on all forms. Submission of incomplete documents delays the BCC-Medicaid application process.

FOLLOWING BCC-MEDICAID APPLICATION SUBMISSION:

- Notification of BCC Medicaid Acceptance or Denial
- Notification is sent to the LCC Case Manager
- If accepted, a Medicaid ID number and date of eligibility are indicated
- WHC staff (local) notifies provider of Medicaid ID # for billing purposes
 - WHC staff (state) sends letter to provider
- WHC - can be billed for approved diagnostic codes
- Medicaid - is to be billed for treatment related services

NOTIFICATION OF CLOSURE TO BCC MEDICAID

- Notification is sent to the LCC Case Manager by Medicaid care manager.
- LCC:
 - Contact client to determine WHC eligibility, schedule for post-treatment follow-up and/or return for re-screening.
 - Schedule appropriate appointments.

WHC REQUIREMENTS FOLLOWING BCC MEDICAID CLOSURE:

- Client must complete new enrollment form
- LCC:
 - Notify state office of enrollment so that [Third Party Administrator](#) can be notified;
 - Add client to [Third Party Administrator](#) list and submit to state office with enrollment form.

Note: If client is not “re-activated”, *WHC* provider reimbursement will be denied.

CONFIDENTIAL FAX

To: Julie Orgill Women's Health Check	From: Phone:
FAX: (208) 334-0657	Date: Pages:



BCC-MEDICAID APPLICATION COVER SHEET

All documents must be complete, and LEGIBLE

CHECK LIST:

- ☐ WHC Enrollment form (current)
- ☐ Presumptive Eligibility form
 - Counsel client regarding the transition from WHC to BCC Medicaid -
 - Including Estate Recovery
 - Breast or cervical cancer section –
 - Date and result of Pap/ CBE /Mammogram
 - Date and result of biopsy, final diagnosis**
 - Initial plan of care
 - List surgeon, oncology and/or radiation physicians
 - Treatment start date if known – or TB Determined
 - Physician name(s) and phone numbers
 - Case Manager's signature and phone number
- ☐ Insurance information (if applicable)
- ☐ Alien document with **Alien ID #** (if applicable)
- ☐ Pathology (**biopsy**) report
- ☐ Relevant physician/clinician reports and notes

Applications without a biopsy report are not valid.

Confidentiality Notice:

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under federal law. If the reader of this message is not the intended recipient, or the employee responsible for delivering message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. **If you have received this communication in error, please notify me immediately and destroy documents.**

Presumptive Eligibility Form

Idaho – Medicaid

vers. (07.2007)

Women's Health Check
PO Box 83720 4th Floor
BOISE, ID 83720-0036



Client Name: _____
Last (Print) First MI

Date of Birth: (____/____/____)
Month Day Year

Age: ____ Date of Initial WHC Enrollment: (____/____/____) Social Security #: ____-____-____
Month Day Year

- ☐ Client was found to need treatment for breast or cervical cancer
☐ Screening and Diagnostic services were provided through Women's Health Check
☐ Client is a U.S. Citizen
☐ Client is not a U.S. Citizen. Alien# is: _____
☐ Client has no health insurance.
☐ Client has health insurance. Copy of Insurance Card attached.

Breast Cancer

Date of clinical breast exam: (____/____/____)
Month Day Year

CBE results: _____

Date of mammogram: (____/____/____)
Month Day Year

Mammogram results: _____
Month Day Year

Date of biopsy: (____/____/____)

Biopsy results: _____

Final diagnosis:

- ☐ Carcinoma *in situ* ☐ Lobular Carcinoma *in situ*
☐ Ductal Carcinoma *in situ* ☐ Invasive Breast Cancer

Cervical Cancer

Pap Smear results: _____

Date of Pap Smear: (____/____/____)
Month Day Year

Date of biopsy: (____/____/____)
Month Day Year

Biopsy results: _____

Final diagnosis:

- ☐ LG SIL (CIN I/Mild dysplasia) - treatment recommended
☐ HG SIL (CIN II/Moderate dysplasia)
☐ HG SIL (CIN III/Severe dysplasia/CIS)
☐ Carcinoma

Initial Plan of Care

Physician (Print)

Telephone

Appointment Date

- ☐ Surgery _____
☐ Radiation _____
☐ Chemotherapy _____
☐ Other _____

Treatment Start Date: (____/____/____)
Month Day Year

I have informed the above named WHC client of her referral to BCC Medicaid for treatment. The client has received the appropriate information regarding BCC Medicaid, her diagnosis and treatment plan.

Client received information: ☐ in person ☐ by phone ☐ by mail

Certified by (Women's Health Check, Local Case Manager)

Phone

Date

Approved by (Women's Health Check, state office)

Date

Claims Submission

CLAIMS SUBMISSION

Claims are paid weekly through a Third Party Administrator for annual exams, mammograms, Pap tests, and diagnostic procedures. Claims for these procedures for *Women's Health Check (WHC)* clients shall be submitted to the [Third Party Administrator](#) within 90 days of the date of service.

CLAIMS SUBMISSION GUIDELINES

- **Providers** (Mammography facilities, labs, clinics, physicians and other healthcare professionals)
All Providers must enter into a Memorandum of Agreement ([MOA](#)) with the State of Idaho Department of Health and Welfare, *WHC* Program prior to providing or submitting claims for services.
 - Submit claims to the *WHC* [Third Party Administrator](#) for eligible *WHC* [services](#) paid at Medicare Rate within 90 days of service. Claims are submitted with customary charges but per [MOA](#) will accept Idaho Medicare rates for services.
 - Submit claims by completing standard [CMS 1500](#) or [UB-04](#) forms, identifying Idaho *WHC* as payor or insurance plan name if client has some insurance coverage.
 - Client can not be billed for any covered service.
 - Signed [MOA](#) indicates acceptance of [CPT rate](#) as full payment for screening and/or diagnostic services.
 - Results of tests and exams must be submitted to *WHC* Local Coordinating Contractor ([LCC](#)) within 30 days from date of service.
 - Provider must advise client prior to providing any non-covered service, making alternative arrangements for payment for any service not listed as covered by *WHC* (see [CPT codes](#)).
 - A new [MOA](#) is required if the Federal Employment Identification Number (EIN) under which claims are submitted to the [Third Party Administrator](#) is changed.
- **Local Coordinating Contractors ([LCC](#))**
 - Submit bills for services provided by your agency to the *WHC* [Third Party Administrator](#).
 - Obtain results of all *WHC* services from Providers, enter those results in *WHC* Real Time system, and submit required forms to the state *WHC* office each month.
 - [LCC](#) must submit list of newly enrolled clients weekly to *WHC*.
 - [LCC](#) must ensure any new providers have signed and returned [MOA](#) to state *WHC* office prior to services being provided.

REQUIREMENTS FOR SUBMISSION OF RESULTS (DATA)

- **Submission of Test Results**
 - Mammography facilities, labs, physicians and other health professionals send all test or exam results to *WHC* [LCC](#) within 30 days from date of service. Screening and diagnostic forms (links) may be used to efficiently and adequately report required data.
 - [LCC](#) submits test results to the state *WHC* program using *WHC* Real Time system.
 - Mammograms must be reported using accepted BI-RADS numerical categories.
 - Pap test results must be reported using BETHESDA categories.
 - CBE results must be reported according to categories listed on *WHC* Real Time system or *WHC* [Screening](#) form (paper).
 - Any screening test identified as abnormal in the *WHC* Real Time system, is considered suspicious for cancer and must receive adequate and timely follow-up (see *WHC* [Screening](#) Form) and appropriate case management.

OTHER

- This program is, by Federal Law, payor of last resort.
- Treatment – Case Manager from LCC shall assist client in applying for Medicaid or help locate any available resource to pay for treatment.

Note: Only [allowable services](#) that are specifically related to annual BCC screening or diagnostic work-up may be submitted.

REIMBURSEMENT PROCEDURE

Reimbursement for *WHC* services is provided through a Third Party Administrator. This requires all providers to officially enlist with the Idaho Department of Health and Welfare through a [Memorandum of Agreement](#).

Submit completed Health Insurance Claim Form ([CMS-1500](#) or [UB-04](#)) to:

United Group Programs
Attention: Idaho Women's Health Check
2500 N. Military Trail Suite 450
Boca Raton, FL 33431
1.800.810.9892 ext 4786

There are very limited [services](#) covered by *Women's Health Check*. To prevent denied claims, remember:

- *WHC* is not a primary payor – services are limited to mammograms, Pap tests, annual exam, and limited diagnostic tests. Refer to the current [CPT code](#) list of services covered.
- Claims (using CMS 1500 or UB-04) are completed and submitted to United Group Programs at the above address within 90 days of the date of service (per [Memorandum of Agreement](#)).
 - For conization or LEEP, the [preauthorization form](#) is completed and submitted to United Group Programs.

Note: *Women's Health Check* is billed a processing fee for all denied claims taking funds away from needed services. Being diligent in billing claims helps save money.

CLAIM DENIALS

All claims are to be submitted to the Third Party Administrator within 90 days from the date of service, but what should you do when a claim is denied on a current *WHC* client for a reimbursable services? Here is how to proceed:

- Do not resubmit claim. A system correction is needed to reprocess and pay.
- You have 60 days to refute the denial from the date of the denial letter. E-mail Minnie Inzer Muniz at the state office **as soon as possible.** Inzerm@dhw.idaho.gov or call 208.332.7311
- Give the client name and reason given for denial.
- If more than 60 days have elapsed, it will be necessary to document reason for delay in writing to:

Women's Health Check
Attn: Minnie Inzer Muniz
P.O. Box 83720
Boise, ID 83720-0036

The sooner the *WHC* state office is contacted, the easier it is to correct and process a claim.

NON-REIMBURSABLE SERVICES

Women's Health Check does not reimburse for the following services:

- Services provided to women prior to enrollment in *WHC*
- Services performed by a non-*WHC* provider
- Services provided to ineligible women (age, income, insurance, or in process of diagnosis or treatment)
- Any client service or procedure not listed on the approved [CPT Code](#) list
- Services where standards outlined in the *WHC* Standards for [Breast](#) or [Cervical](#) Cancer Screening are not met
- Screening services that are incomplete (CBE without mammogram, Pap with inadequate specimen)
- Services for any disease or medical condition other than breast or cervical cancer early detection

All test or exam results must be reported to the appropriate *WHC* Local Coordinator Contractor ([LCC](#)) within 30 days from date of service.

Note: Treatment is not a covered service through *WHC*, however women screened and diagnosed with breast or cervical cancer are eligible for treatment coverage through Medicaid if they are under age 65, a U. S. Citizen or eligible alien, reside in Idaho, and have no creditable insurance.

REIMBURSEMENT PROCEDURE

Reimbursement for *WHC* services is provided through a Third Party Administrator. This requires all providers to officially enlist with the Idaho Department of Health and Welfare through a [Memorandum of Agreement](#).

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Women's Health Check

A breast and cervical cancer screening program

WOMEN'S HEALTH CHECK REIMBURSEMENT RATES 2008					
PRIMARY CPT	ALLOWABLE CPT*	PROCEDURE	GLOBAL RATE	TECHNICAL COMPONENT	PROFESSIONAL COMPONENT
10021		FINE NEEDLE ASPIRATION; WITHOUT IMAGING GUIDANCE	\$127.78		
10022		FINE NEEDLE ASPIRATION; WITH IMAGING GUIDANCE	\$133.93		
19000		PUNCTURE ASPIRATION OF CYST OF BREAST;	\$103.53		
19001		PUNCTURE ASPIRATION CYST BREAST; EA ADD CYST	\$25.33		
19100		BX BREAST; PERQ NDLE CORE W/O IMAG GUID-SEP PROC	\$125.75		
19101		BIOPSY OF BREAST; OPEN INCISIONAL	\$287.29		
19102		BX BREAST; PERCUT NEEDLE CORE USING IMAGING GUID	\$209.20		
19103		BX BREAST; PERC-VACUUM/ROTATING DEV W/IMAG GUID	\$535.14		
19120		EXC BREAST CYST TUMR/LES OPEN MALE/FEMALE 1/>	\$404.39		
19125		EXC BRST CYST/LES ID PRE-OP RAD MARKR OPN; 1 LES	\$446.43		
19126		EXC BRST CYST/LES OPN; EA ADD LES ID RAD MARKR	\$146.97		
19290		PREOPERATIVE PLACEMENT NEEDLE LOC WIRE BREAST;	\$152.67		
19291		PREOP PLCMT NDLE LOC WIRE BREAST; EA ADD LESION	\$66.37		
19295		IMAG GUID PLCMT METAL CLIP PERQ DURING BREAST BX	\$90.98		
57452		COLPOSCOPY CERVIX INCLUDING UPPER/ADJ VAGINA;	\$103.50		
57454		COLPSCPY CERV UP/ADJ VAG; BX CERV&ENDOCERV CURET	\$146.52		
57455		COLPOSCOPY CERV INCL UP/ADJ VAGINA; W/BX CERVIX	\$136.49		
57456		COLPSCPY CERV INCL UP/ADJ VAG; W/ENDOCERV CURET	\$128.90		
57460-	pre-auth reg	ENDOSCOPY W LOOP ELECTRODE BIOPSY(S) OF THE CERVIX	\$295.11		
57461-	pre-auth reg	ENDOSCOPY W LOOP ELECTRODE CONIZATION OF THE CERVIX	\$328.84		
57500		BIOPSY, SINGLE OR MULTI, OR LOCAL EXCISION OF LESION	\$129.71		
57505		ENDOCERVICAL CURETTAGE (Not done as part of D&C)	\$96.03		
57520-	pre-auth reg	CONIZATION OF CERVIX W/WO FULGURATION OR DILATION	\$292.57		
57522-	pre-auth reg	LOOP ELECTRODE EXCISION PROCEDURE	\$249.16		
58100		ENDOMETRIAL SAMPLING W/WO ENDOCERVIAL SAMPLING	\$104.75		
58110		ENDOMETRIAL SAMPLING BIOPSY W COLPOSCOPY	\$47.30		
76098		RADIOLOGICAL EXAMINATION SURGICAL SPECIMEN	\$20.67	\$12.80	\$7.87
76645		US BREAST B-SCAN &OR REAL TIME W/IMAGE DOC	\$82.50	\$55.57	\$26.93
76942		US GUID NDLE PLCMT IMAGING SUPERVIS&INTEPR	\$169.77	\$136.22	\$33.55
77031		STEREOTACT GUID BRST BX/NEEDLE PLCMT-EA LES-RS&I	\$242.05	\$162.61	\$79.44
77032		MAMMO GUID NDLE PLCMT BREAST EA LESION RAD S&I	\$64.91	\$37.18	\$27.73
77055	G0206	DIAGNOSTIC MAMMOGRAPHY; UNILATERAL	\$80.89	\$45.72	\$35.17
77056	G0204	DIAGNOSTIC MAMMOGRAPHY; BILATERAL	\$102.13	\$58.67	\$43.46
77057	G0202	SCREENING MAMMOGRAPHY BILATERAL	\$81.10	\$45.93	\$35.17
87621		INF AGT-DNA/RNA; PAPILOMAVIRUS HUMAN-AMP	\$49.04		
88141		CYTOPATH CERV/VAGINAL; RQR INTEPR PHYSICIAN	\$25.29		
88142	88143,88174,88175	CYTOPATH THIN PREP CERV/VAG; MNL SCR UND PHYS SUPV BI ANNUAL SCREENING ON NORMAL RESULTS	\$28.31		
88164	88147,88148,88150,88165	CYTOPATH SLIDES CERV/VAG; MNL SCR UND PHYS SUPV	\$14.76		
88172		CYTOPATH FNA EVAL; IMMED CYTOHISTOLIC STUDY	\$50.96	\$20.46	\$30.50
88173		CYTOPATH EVALUATION FINE NDLE ASPIR; INTEPR&RPT	\$130.96	\$61.65	\$69.31
88305		LEVEL IV - SURGICAL PATHOLOGY GROSS & MICRO EXAM	\$100.73	\$63.16	\$37.56
88307		LEVEL V- SURG PATH GROSS/MICRO EXAM	\$198.90	\$118.25	\$80.65
88331		PATH CNSLT DUR SURG; 1ST TISS BLK W/FZ-SNGL SPEC	\$87.64	\$27.07	\$60.57
88332		PATH CNSLT DUR SURG; EA ADD TISS BLK W/FRZN SECT	\$39.61	\$9.52	\$30.09
99201		OFC/OUTPT VISIT E&M NEW SELF LIMIT/MINOR 10 MIN	\$36.23		
99202		OFC/OUTPT VISIT E&M NEW LOW-MOD SEVERITY 20 MIN	\$62.61		
99203	99204,99205,99385,99386,99387*	OFC/OUTPT VISIT E&M NEW MODERATE SEVERITY 30 MIN *Reimbursable for Medicare-Part B unenrolled women only.	\$91.79		
99211		OFC/OUTPT VISIT E&M ESTAB NO PHYS PRES 5 MIN	\$19.56		
99212		OFC/OUTPT VISIT E&M EST SELF-LIMIT/MINOR 10 MIN	\$37.32		
99213	99214,99215,99395,99396,99397*	OFC/OUTPT VISIT E&M EST LOW-MOD SEVERITY 15 MIN *Reimbursable for Medicare-Part B unenrolled women only.	\$60.94		
99241		OFFICE CNSLT NEW/ESTAB SELF LIMIT/MINOR 15 MIN	\$48.04		
99242		OFFICE CNSLT NEW/ESTAB LOW SEVERITY 30 MIN	\$89.82		
99243		OFFICE CNSLT NEW/ESTAB MODERATE SEVERITY 40 MIN	\$123.54		
99244	99245	OFFICE CNSLT NEW/ESTAB MOD-HIGH SEVERITY 60 MIN (approp of use determined by Grantee's Medical Advisory Board)	\$182.54		
00400	00940	ANESTHESIA FOR BREAST BIOPSY, CONE, LEEP	\$62.04	+\$20.68 for each 15 minutes (up to \$206.80)	
99070		Supplies over and above those usually included with the office visit or other services rendered (trays, supplies or materials provided)	Not to exceed \$100.00		

Highlighted procedures require pre-authorization from the WHC state office: contact Julie at (208) 334-5971

*Allowable CPT codes are procedures that can be paid by UGP, but they are at the primary Medicare rate.

Forms



Idaho Women's Health Check Form Instructions



(vers. 10.2008)

The following information highlights required program data, defines terms, and explains basic instructions for completing Idaho Department of Health and Welfare's Women's Health Check program forms.

What's New

Women's Health Check data requirements

As a result of new data requirements implemented by the Centers for Disease Control and Prevention (CDC), WHC enrollment, screening, and diagnostic forms are updated to collect new data elements beginning January 1, 2009.

Women's Health Check eligibility requirements

A woman must be a United States citizen or eligible alien (with at least 5 years of residency) to qualify for the Women's Health Check program. In addition, WHC clients are required to provide a social security number. If not a citizen, provide an Alien ID card number and issue date.

BCC Medicaid citizenship requirements for women needing treatment for cancer

In accordance with The Deficit Reduction Act of 2005, Section 6036, individuals are required to provide documentation of citizenship or nationality when initially applying for Medicaid or upon recipient's first Medicaid re-determination. Therefore, any woman eligible for the Women's Health Check program is now required by Medicaid to provide proof of citizenship, an original birth certificate or documentation of citizenship, should she need treatment provided through BCC Medicaid.

To obtain an original birth certificate:

- Idaho citizen: Complete the [Vital Statistics Certificate Request form](#) and fax it to the state office along with presumptive eligibility at (208) 334-0657. Women's Health Check's may request a free copy of the official birth certificate for Idaho born citizens from Vital Statistics with a client signed Permission for Women's Health Check Birth Certificate Request form.
- U.S. citizen born in another state: The client will need to request an official document from her birth state. The Department of Health and Welfare recommends the following site www.vitalchek.com for obtaining birth certificates. When the client receives her original birth certificate, it must be verified and copied by the Local Coordinating Contractor and then faxed to the state office. The client will need to mail or bring her documents to the case management site.

Note: This need for a birth certificate does not change our presumptive eligibility process. Women will still be able to start treatment in a timely manner, however they must obtain and present an original birth certificate in order to continue on Medicaid.

Helpful Definitions

Presumptive Eligibility: The period of time defined as the month following the month in which the WHC client is referred for BCC Medicaid.

Reminders

If you have questions or concerns regarding any portion of Women's Health Check enrollment, screening, or diagnostic forms, please contact the Women's Health Check state office Monday-Friday 8:00am—5:00pm Mountain Standard Time.

Women's Health Check
Idaho Department of Health and Welfare
450 W. State Street, 4th Floor
P.O. Box 83720, Boise, ID 83720-0036
www.healthandwelfare.idaho.gov
Phone: (208) 334-5805
Fax: (208) 334-0657

Additional Women's Health Check program resources include:

Idaho Careline
Call 2-1-1 or 1-800-926-2588

Women's Health Check Real Time Database
**You must be a contractor with the Women's Health Check program to access this database.*
www.whcidaho.org

General Instructions

These instructions are developed to give a Women's Health Check enrollment site a better understanding of required information and services covered by the program. Terminology and questions are defined by the Centers for Disease Control and Prevention and Women's Health Check for the improvement of service to the women of Idaho.



Idaho WHC Enrollment Form and Program Consent Information Release

The enrollment form is intended to be completed by the person determining eligibility and establishing a client's minimum qualifications. This form is used to determine a woman's eligibility for enrollment or re-enrollment into the Women's Health Check program. A woman must renew her eligibility by re-enrolling every subsequent year after her initial enrollment to continue using the program for screening and diagnostic services. After eligibility has been verified verbally, the client should complete the remaining sections and Program Consent Information Release (page 2 of enrollment), giving her consent and information release by signing and dating both pages. Please review the completed form to ensure all questions have been answered.

For LCC Use

On the enrollment form, you will notice a box on the top of the form labeled "For LCC Use". This box is intended for LCC filing or tracking purposes in case management. LCC's may use this space to meet their local needs.

Client Eligibility

Located below the form title, the Client Eligibility box should be completed by the person determining eligibility prior to the client entering her personal information. WHC clients (new and returning) must be U.S. citizens or eligible aliens to receive BCC Medicaid if diagnosed through the Women's Health Check program. This section will determine if a woman meets the minimum requirements.

After asking the client questions 1-5, please verify eligibility by checking the 4 listed enrollment requirements in the lower right hand box (in the Client Eligibility section) and signing on the line after "Eligibility verified by:".

Client Information

Once eligibility has been established, the client should complete the client information section and page 2 (Program Consent and Information Release). The client's signature and date are required on both pages.

Question 1. Client Information

The client is asked to enter basic personal information for data management, tracking purposes, and eligibility for the program. You will notice a client is asked whether they are a U.S. Citizen or have Alien status; women must be a legal alien or US citizen to receive Women's Health Check services.

Question 2. Ethnicity and Race

All answers in this section are required. The preferred method of identifying ethnicity and race is self-identification by the woman. Unknown in this context can mean: the woman wasn't asked, the answer wasn't recorded, the woman doesn't know, or the woman refused to answer. Please check to make certain she has answered both questions.

Question 3. Emergency Contact

This information is collected in order for the program to contact someone other than the client in case of emergency. This person's information will be kept confidential and not used for any other purposes.

Question 4. How did you hear about this program?

The client may check all that apply. This information is used to plan and evaluate future recruiting efforts.

Client Signature

Located at the bottom of the enrollment form, the client must check all boxes that apply, in addition to her signature, in order to complete enrollment into the Women's Health Check program. The date entered is the date the client completes and signs the form.

Program Consent and Information Release (page 2 of enrollment)

The client must read and mark each of the boxes above the line. The enrollment site is required to maintain a copy of the Idaho Health and Welfare Privacy Practices available for clients to read. If the client checks the last box requesting a personal copy of the IDHW Privacy Practice, please fax her Program Consent and Information Release to the WHC state office at (208) 334-0657 immediately. The state office will send her a copy.



WHC Screening Form

This form is intended to be used by the provider screening a Women's Health Check client for breast or cervical cancer. The page is divided into two columns: the left for breast screening and the right for cervical screening. If a client is only being screened for one, please indicate that by checking the appropriate box above the respective column. Once completed, the form should be faxed to a provider's Local Coordinating Contractor (LCC) for data entry.

Breast Screening (ages 50-64)

Breast Record Only Checkbox

Please mark if the client is not eligible for or not receiving cervical screening services.

History

Question 1. Previous Mammogram

This question is asked to determine whether a client has ever had a previous mammogram, regardless of their status in the Women's Health Check program. The options for answering are yes, no, and unknown. If yes, please enter date (month, date (optional), and year) of prior mammogram if known. Unknown can mean: woman was not asked, answer was not recorded, woman does not know or refused to answer.

Question 2. Breast Symptoms

This question refers to whether or not a client "self reports" and provides information regarding her motivation for screening. The Breast Symptoms element provides information regarding what brought the woman to screening. Was she asymptomatic or did she think she had a problem?

Question 3. Indications for today's mammogram

This question refers to the purpose of today's mammogram. For the purpose of this program, the *initial* mammogram is the first mammogram of the screening cycle. A *diagnostic* mammogram may be the initial mammogram when the client is symptomatic or has an abnormal CBE and this is the first mammogram of the cycle.

Routine screening mammogram (screening)	Routine or annual screening schedule without any breast symptoms.
Initial mammogram to evaluate additional symptoms, abnormal CBE result, or follow-up from a previous abnormal mammogram (diagnostic)	Today's mammogram is done as an additional evaluation of a recent mammogram or due to current symptoms or abnormal CBE, but is the first mammogram of the screening cycle.
Referred into the program for diagnostic evaluation; Date of initial mammogram (already completed); Date of referral into program; and BIRADS results 1, 2, 3, 4, 5, or 0.	Initial mammogram performed outside of WHC and the client is being referred into the program for diagnostic evaluation. Include BIRADS result of mammogram, date of initial mammogram, and date of referral into the program.
Mammogram not done. Patient only received CBE, or proceeded directly for other imaging or diagnostic work-up	A woman only receives a CBE and does not receive a mammogram, but instead goes directly to diagnostic work-up.

Question 4. Clinical Breast Exam Results

Normal/Benign/Fibrocystic	Not suspicious for cancer. No additional concerns.
Discrete palpable mass (suspicious for cancer); Nipple/areolar scaliness; Bloody or serous nipple discharge; or Skin dimpling or retraction.	Results <u>require</u> additional evaluation, regardless of the initial mammogram findings, and should have abnormal breast work-up form completed. <i>Note: <u>These choices all require diagnostic work-up.</u></i>
Refused/Not done at this visit, but needed	This result should be used when client refuses a clinical breast exam or a trained CBE Professional is not available.
Not needed, normal CBE in past 12 mos.	This result used when a woman had a normal CBE in the past 12 months and it is not necessary at today's visit.

Provider reports findings from clinical breast exam, including date and provider or facility.

CBE funded by WHC?

Yes: If office visit is paid in whole or part with WHC funds.

No, Paid by other resource: If CBE is done outside of the program but the woman receives a WHC funded mammogram.

WHC Screening Form (cont.)



Question 5. Mammogram Results

Conventional or Digital mammogram should be marked. This section is to report the result of the initial mammogram in the screening cycle using the American College of Radiology (ACR) Breast Imaging Reporting and Database System (BIRADS), with the reported category is to be determined by the Radiologist.

BI-RADS		
1 or 2	Negative or Benign	Not suspicious for cancer.
3	Probably Benign— <i>STFU required</i>	A response of Probably Benign should not be reported as the initial mammogram result unless a complete diagnostic work-up was performed (either within or outside of the program) prior to the current cycle. For example, if this is the first mammogram ever for the woman a response of Probably Benign can not be reported. The mammogram should be coded as a 4, 5, or 6 and additional breast procedures such as an ultrasound or additional mammographic views should be performed to rule out cancer. ¹
4	Suspicious Abnormality (consider biopsy)	Biopsy should be considered. Diagnostic work-up required.
5	Highly Suggestive of Malignancy	Appropriate action should be taken. Diagnostic work-up required.
0	Incomplete— <i>need additional imaging</i>	A response of incomplete is used to represent those instances where the radiologic assessment is incomplete if, for example, magnification or additional views are needed to determine a final interpretation of the mammogram films. Additional imaging required.

¹Once the client receives diagnostic testing and a final diagnosis is obtained, any Extra views would be considered the second mammogram of the cycle and should be reported on the *Abnormal Breast Diagnostic Follow-up* form. Extra views alone are not adequate for a diagnostic work-up. Additional evaluations, such as ultrasound, biopsy or surgical consultation are needed to complete a cycle for a diagnostic work-up. Once the client receives diagnostic testing and a Final Diagnosis is obtained, any future mammograms can be coded Probably Benign.

Film Comparison to evaluate Assessment Incomplete?

Yes: The assessment of the initial mammogram is incomplete and the radiologist will require a review of previous mammographic films to make a final interpretation.

No: Initial mammogram is complete without further film comparison.

Mammogram funded by WHC?

Yes: If the mammogram was paid for in whole or part with WHC funds.

No, Paid by other resource: When reporting a non-program funded mammogram, record the result that has lead to diagnostic work-up paid with WHC program funds.

Question 6. Breast Cycle Outcome

This item was created to eliminate confusion about which women are to have immediate additional imaging or diagnostic work-up. This item should reflect the clinical recommendation for additional imaging or diagnostic work-up.

Routine Annual Screening	No additional imaging or diagnostic procedures are recommended.
Diagnostic Work-up Planned	Complete WHC Abnormal Breast Diagnostic Follow-up form.
Short term Follow-up Planned	Use recommendation box to write what and when follow-up is planned.

Cervical Screening (ages 40-64)

Cervical Record Only Checkbox

Please mark if the client is not eligible for or not receiving breast screening services.

History

Question 1. Prior Pap test and Date

This question is asked to determine whether a client has had a previous Pap test, regardless of their status in the Women's Health Check program. The options for answering are yes and no. If yes, please enter date (month, date (optional), and year) of previous Pap test if known.

Question 2. Hysterectomy for Cervical Neoplasia/Cervical Cancer?

To report whether a woman had a hysterectomy due to cervical neoplasia or cervical cancer. If yes, the client is eligible for yearly screening.



WHC Screening Form (cont.)

Question 3. Indications for today's Pap test

To report the indication/purpose of the cervical cycle.

Routine Pap test (screening)	Pap test was performed as part of a routine screening schedule.
To evaluate additional symptoms, abnormal test result, or follow-up from previous abnormal Pap test result	Pap test was performed for a woman under management for a cervical abnormality detected prior to this cycle.
Referred into the program as a diagnostic evaluation; Date of referral into program; and Pap test Result	Pap test was performed outside of the program and the woman was referred into WHC for diagnostic evaluation. Referral date must be completed and a valid Pap test result should be provided.
Pap test not done. Previous result ASC-US. Patient proceeded directly for HPV test	Woman did not have a Pap test and went directly to HPV testing or diagnostic evaluation.

Question 4. Pelvic Exam Result

Enter the date of exam, provider or clinic name, and results.

Normal	Follow routine schedule.
Abnormal—NOT suspicious for cervical cancer	Cervical consult not covered.
Abnormal—suspicious for cervical cancer	If abnormal, suspicious for cervical cancer, <u>requires a gynecologic consultation</u> .

Question 5. Pap test Results

Enter Pap test date, facility name, and results of screening Pap test using the 1991 Bethesda System.

Negative for intraepithelial lesion or malignancy	Follow routine screening.
Atypical squamous cells of undetermined significance (ASC-US)	HPV testing or short term follow-up should be planned.
Low grade squamous cells intraepithelial lesion (LSIL); Atypical squamous cells, can not exclude high grade (ASC-H); High grade squamous intraepithelial lesion (HSIL); Squamous Cell Carcinoma; Abnormal Glandular Cells (AGC); Endocervical adenocarcinoma in situ (AIS); or Adenocarcinoma	<u>These results all require diagnostic work-up. Use WHC Abnormal Cervical Diagnostic Follow-up form.</u>
Other	The purpose of this option is to include results that don't fit into the other Bethesda result categories. Please try to use this item appropriately. Reclaiming inappropriate "other" responses is time-consuming and could potentially result in the loss of valuable data. Acceptable categories to report as Other include "Endometrial Cells" and "Specimen Lost before evaluation".

Pap test funded by WHC?

Yes: If the Pap test was paid for in whole or part with WHC funds.

No, Paid by other: When reporting a non-program funded Pap test result that has lead to diagnostic work-up paid with WHC program funds.

Specimen Adequacy

This is an item that gives the program a way to report specimen adequacy as noted under the Bethesda System. Unsatisfactory should be reserved for specimens that were evaluated and found to be unsatisfactory for determining a result.

Specimen Type

To indicate how the Pap test specimen was collected.



WHC Screening Form (cont.)

Question 6. HPV Test Result

Enter date. This should be the date of sample collection, not the date the HPV test was actually performed.

An HPV test performed immediately following an ASC-US Pap test result should be reported in this section. In the event of an ASC-US Pap test result and a Positive HPV test result, then diagnostic work-up should be planned. An HPV test performed for a woman under surveillance (for example, follow-up at 6-12 months) should be reported in a subsequent cycle.

Test funded by WHC?

Yes: If the test was paid for in whole or part with WHC funds.

No, Paid by other resource: A response of "No" should be used when reporting an HPV test not paid with WHC funds.

Question 7. Cervical Cycle Outcome

To indicate the clinical recommendation for *immediate* diagnostic work-up.

Routine Screening	No additional imaging or diagnostic procedures are recommended.
Diagnostic Work-up Planned	Complete diagnostic follow-up form.
Short term Follow-up Planned	Use recommendation box to indicate what and when follow-up is planned.

WHC Abnormal Breast Diagnostic Follow-up Form



The purpose of the Abnormal Breast Diagnostic Follow-up form is to document what procedures were completed to arrive at a final outcome. Please answer yes to the questions that apply to the client or leave a section blank if it is not applicable. Complete only the sections that pertain to the patient's clinical need.

Question 1. Breast Imaging

This section collects information regarding additional imaging done during this cycle. If performed, enter date and facility name.

Additional Mammographic Views?

This item is used for the reporting of compression views, cone compression, magnification views and diagnostic mammograms. Please answer "Yes" if done. If the initial mammogram reported was a diagnostic mammogram, then it should NOT be reported in this item. This will help eliminate "double counting" of mammograms.

Ultrasound?

This item is used for the reporting of ultrasound or sonography. Please answer "Yes" if done. If ultrasound is performed more than once for a woman during separate visits in the same cycle to obtain a final imaging outcome, then it is only necessary to complete this item once as Yes.

Results of imaging (BI-RADS categories)

1	Negative
2	Benign
3	Probably Benign— <i>STFU required</i>
4	Suspicious Abnormality (consider biopsy)
5	Highly Suggestive of Malignancy
0	Incomplete— <i>need additional imaging</i>

Recommended follow-up covered by WHC

Please check course of action planned. The options listed are recommended follow-up covered by the WHC program in their respective category and are not intended to be the complete list of available options.

Question 1a. Final Imaging Outcome

The purpose of this item is to report the assessment from all of the imaging procedures performed, including comparison with previous films, needed to arrive at a final outcome from images. Date and result according to BI-RADS category must be entered.

BI-RADS 1	Negative (BI-RADS 1)
BI-RADS 2	Benign finding (BI-RADS 2)
BI-RADS 3	Probably Benign—initial short interval follow-up suggested (BI-RADS 3)
BI-RADS 4	Suspicious Abnormality (consider biopsy) (BI-RADS 4)
BI-RADS 5	Highly Suggestive of Malignancy. Appropriate action should be taken (BI-RADS 5)
Unsatisfactory	This applies if the mammogram was technically unsatisfactory and could not be interpreted by radiologist
Additional Imaging Pending	Result pending

Question 2. Surgical Consultation Outcome

This item is used for reporting if a second opinion or surgical consult was performed by a breast specialist. A breast specialist is a clinician who identifies him/herself as an expert in breast health. This may be a breast surgeon, radiologist, oncologist, primary care provider, etc. Please answer yes or no. If yes, enter date and provider name.

Consult Outcome

No intervention at this time
Core Biopsy
Fine Needle Aspiration

Recommended follow-up covered by WHC

Please check course of action planned. The options listed are recommended follow-up covered by the WHC program in their respective category and are not intended to be the complete list of available options.

WHC Abnormal Breast Diagnostic Follow-up Form (cont.)



Question 3. Consultant-Repeat CBE and Results

This item is used for reporting if a repeat clinical breast exam was performed by a breast specialist. A breast specialist is a clinician who identifies him/herself as an expert in breast health. This may be a breast surgeon, radiologist, oncologist, primary care provider, etc. Please answer yes or no. If yes, enter date and provider name. Indicate consult outcome (result of CBE) according to categories listed.

Recommended follow-up covered by WHC

Please check course of action planned. The options listed are recommended follow-up covered by the WHC program in their respective category and are not intended to be the complete list of available options.

Question 4. Fine Needle/Cyst Aspiration and Results

This item is used for reporting if a fine needle or cyst aspiration was performed. Please answer yes or no. If yes, enter date and provider name. Indicate results according to choices listed.

Recommended follow-up covered by WHC

Please check course of action planned. The options listed are recommended follow-up covered by the WHC program in their respective category and are not intended to be the complete list of available options.

Question 5. Tissue Biopsy/Lumpectomy

This item is used for reporting if a core biopsy or excisional biopsy was being performed. Please answer yes or no. If yes, enter date and provider name. Indicate result according to choices listed.

A lumpectomy intended as a treatment procedure should not be reported in this item. However, in some cases an excisional biopsy is performed and upon pathological review it is determined that the margin of the tumor falls completely within the biopsy specimen. As a result, the biopsy intended to be a diagnostic procedure also serves as treatment (lumpectomy). Such a procedure can be reported as a diagnostic procedure, as would an incisional biopsy or core needle biopsy. Supportive procedures such as stereotactic localization do not need to be reported.

Recommended follow-up covered by WHC

Please check course of action planned based on pathology results.

Question 6. Were any other breast procedures performed?

This item is used to indicate if breast diagnostic procedures other than those specified in questions 1 – 5 were performed to help determine a final diagnosis for a woman. Only diagnostic procedures which can provide a diagnosis of cancer or not cancer should be reported in this item. Please answer yes or no. If yes, use line to report any other diagnostic procedure.

Question 7. Were any imaging or diagnostic procedures funded by Women's Health Check?

To indicate if one or more additional breast procedures were paid for with WHC funds. If the funding source for the breast diagnostic procedures can be documented, then a response of "Yes" or "No" may be reported.

Question 8. Diagnostic Work-up Status

To specify the status of the breast final diagnosis or imaging. Mark appropriate box. Use lines provided for additional comments related to work-up status.

Pending	Pending indicates that not all of the planned diagnostic tests have been completed and therefore a final diagnosis has not yet been determined.
Work-up complete	A status of Work-up Complete indicates that the diagnostic testing is complete and that the final diagnosis and date of final diagnosis are known.
Lost to follow-up	A status of Lost to Follow-up should be reported if prior to the initiation or completion of diagnostic work-up a woman moves to a location beyond the program's range of service delivery (e.g. to another country), she can not be located by the program (e.g. moved), or a woman dies. This should be reported when tracking efforts have been attempted in accordance with the program's written protocol, but were unsuccessful.
Work-up refused	A status of Work-up Refused should be reported if a woman severs her relationship with the program. For example, a woman may decline the recommended diagnostic work-up or may choose to have the diagnostic work-up performed by a provider outside of the program.

WHC Abnormal Breast Diagnostic Follow-up Form (cont.)



Question 9. Final Diagnosis

To specify breast final diagnosis. Enter date of final diagnosis and indicate outcome according to boxes provided or comment as needed.

Breast Cancer not diagnosed
Ductal Carcinoma <i>in situ</i>
Lobular Carcinoma <i>in situ</i>
Invasive Breast Cancer
Other

The CDC is aware that there are some rare instances where the Final Diagnosis may be both DCIS and LCIS. In these cases, the Final Diagnosis should be reported and treated as DCIS. If multiple primary tumors are detected in one screening, then report the most serious diagnosis. For example, if a woman is diagnosed with both In Situ and invasive breast cancer, then report the invasive cancer as the final diagnosis.

If the breast cancer is determined to be a recurrence, then the final diagnosis should be reported as Breast Cancer not diagnosed. Such cases should be documented in detail in the program's data system. Final diagnosis is an important outcome measure for WHC, thus it is critical this data is complete, timely, and accurate.

Question 10. Treatment Information (to be completed if cancer is diagnosed)

To specify status of standard or conventional treatment for breast cancer. Status of Treatment is an important outcome measure for WHC. It is important to know the percentage of women diagnosed with breast cancer that have started treatment, thus it is critical this data is complete, timely, and accurate.

Treatment started - indicate date initial treatment started	The fact that a woman is referred for standard treatment is not sufficient confirmation that treatment has been started. A woman should be classified as having started treatment only after the program has confirmed that a plan for standard treatment of the cancer has been developed and started.
Treatment pending - indicate date	
Lost to follow-up - indicate date	Lost to follow-up should be reported if following a diagnosis, but prior to the initiation of treatment, a woman moves to a location beyond the program's range of treatment services (e.g. to another state or country), she cannot be located (e.g. moved), or dies prior to the initiation of treatment. This should be reported when tracking efforts have been attempted in accordance with the program's written protocol but were unsuccessful.
Treatment not needed - indicate date	Treatment not needed should be reported in instances where the clinician and the woman jointly agree that treatment of the cancer would adversely affect the woman's quality of life. This may occur, for example, in cases of late or end stage cancers.

WHC Abnormal Cervical Diagnostic Follow-up Form



The purpose of the Abnormal Cervical Diagnostic Follow-up form is to document what procedures were completed to arrive at a final outcome. Please answer yes to the questions that apply to the client or leave a section blank if it is not applicable. Complete appropriate questions according to patient need.

Question 1. Gynecologic consultation

This question is asked to determine if a specialist was needed to complete a visual inspection of the vaginal/cervical area and to recommend a plan. Please answer yes or no. If yes, enter date and provider name.

Consult Outcome

Normal/Benign/Inflammation	No additional procedures are recommended
Other abnormality	Not suspicious for cervical cancer
Suspicious for cervical cancer	Additional testing needed

Recommended follow-up covered by WHC

Please check course of action planned. The options listed are recommended follow-up covered by the WHC program in their respective category and are not intended to be the complete list of available options.

Question 2. Colposcopy

This item should always be completed when diagnostic work-up for Cervical Dysplasia or Cancer is planned. Please answer yes or no. If yes, enter date and provider or facility name.

Colposcopy without Biopsy and Colposcopy with Biopsy and/or ECC are mutually exclusive; both items should not be coded in the same record. If both procedures were performed during a single screening cycle, code the more definitive procedure.

Results

Provides the program with a tissue result that determines if the client needs treatment, short term follow-up, or routine screening. Enter result according to choices listed.

Recommended follow-up covered by WHC

Please check course of action planned. The options listed are recommended follow-up covered by the WHC program in their respective category and are not intended to be the complete list of available options.

Question 3. Other Biopsy Options

These are additional procedures sometimes necessary to perform to diagnose cervical cancer.

Endocervical Curettage alone (ECC)

This item is used for the reporting of a stand-alone ECC. It should not be used to report ECC that is done in conjunction with colposcopy. ECC done in conjunction with a colposcopy should be reported in question 2 (Colposcopy with Biopsy and ECC). Please answer yes or no. If yes, enter date and provider or facility name.

Loop Electrosurgical Excision Procedure (LEEP)

This item is used for the reporting of LEEP performed as a diagnostic procedure, and should not be used to report LEEP performed as treatment. In some instances, LEEP is appropriate following a HSIL Pap result. Please answer yes or no. If yes, enter date and provider or facility name. State approval needed prior to this procedure. Contact the State office in this situation. Please contact Julie Orgill at (208) 334-5971.

Cold Knife Cone (CKC)

This item is used for the reporting of Cold Knife Cone performed as a diagnostic procedure and should not be used to report Cold Knife Cone performed as treatment. Please answer yes or no. If yes, enter date and provider or facility name. State approval needed prior to this procedure. Please contact Julie Orgill at (208) 334-5971.

Results

Provides the program with a biopsy result that determines if the client needs treatment, short term follow-up, or routine screening. Indicate result according to choices provided.

Recommended follow-up covered by WHC

Please check course of action planned. The options listed are recommended follow-up covered by the WHC program in their respective category and are not intended to be the complete list of available options.

Question 4. Were any other cervical procedures performed?

This item is to indicate if cervical diagnostic procedures other than those specified in questions 1-3 were performed to determine a final diagnosis for a woman. Only diagnostic procedures performed as management of a suspected cervical lesion, such as endometrial biopsy or the excision of endocervical polyps. It is appropriate to report biopsies of other genital structures such as the vagina or vulva only for women who do not have a cervix. This item should NOT be used for the reporting of repeat Pap tests or treatment procedures such as cryosurgery, hysterectomy, laser, or cautery. Please answer yes or no. If yes, write in the name of the other procedure.

WHC Abnormal Cervical Diagnostic Follow-up Form (cont.)



Question 5. Were any imaging or diagnostic procedures funded by Women's Health Check?

To indicate if one or more additional cervical procedures were paid for with WHC funds.

Question 6. Diagnostic Work-up Status

Final diagnosis is an important outcome measure for the Women's Health Check program, thus it is critical this data is complete, timely, and accurate. Check only one. Use space provided for additional comments relating to work-up status.

Pending—cycle done at this time but work-up not complete. Action should be taken to complete work-up within one year.	Pending indicates that not all of the planned diagnostic tests have been completed and therefore a final diagnosis has not yet been determined. A record should not be pending for more than one year. Such a record should be reviewed for additional information and appropriately updated.
Work-up complete	A status of Work-up Complete indicates that the diagnostic testing is complete and the final diagnosis and date of final diagnosis are known.
Lost to follow-up	A status of Lost to Follow-up should be reported if prior to the initiation or completion of diagnostic work-up a woman moves to a location beyond the program's range of service delivery (e.g. to another country), she can not be located by the program (e.g. moved), or a woman dies. This should be reported when tracking efforts have been attempted in accordance with the program's written protocol, but were unsuccessful.
Work-up refused	A status of Work-up Refused should be reported if a woman severs her relationship with the program. For example, a woman may decline the recommended diagnostic work-up or may choose to have the diagnostic work-up performed by a provider outside of the program.

Question 7. Final Diagnosis

To specify the cervical final diagnosis. Choose one outcome as listed.

Enter date. This item is used for reporting the date the clinical diagnosis was made or the date on which the clinical decision was made that no cancer is present.

Normal/Benign/Inflammation	If the cervical findings are normal, then the cervical final diagnosis should be reported as Normal/Benign/Inflammation.
HPV/Condylomata/Atypia	Final diagnosis does not require cancer treatment.
CIN 1/mild dysplasia	In rare cases, treatment might be recommended.
CIN 2/moderate dysplasia	In most cases, treatment might be recommended.
CIN 3/severe dysplasia/carcinoma <i>in situ</i>	Final diagnosis of Adenocarcinoma In Situ (AIS) <i>of the cervix</i> should be reported as CIN3/ CIS/AIS. AIS <i>of the cervix</i> is an in situ pre-cancerous condition that requires treatment.
Invasive Carcinoma	The term "invasive cervical carcinoma" is meant to refer to histologic characteristics of tumors found primarily within the cervix. Final diagnosis of Adenocarcinoma <i>of the cervix</i> , Invasive Adenocarcinoma <i>of the cervix</i> , or squamous cell carcinoma <i>of the cervix</i> should be reported as Invasive cervical carcinoma. These are invasive cervical carcinoma diagnoses that require treatment and should be reported to the Cancer Registry.
Adenocarcinoma	
Other	Sarcomas that are of a histologic type of primary cancer that occurs in the cervix may be considered invasive cervical carcinoma and may be reported as Other. *Melanoma, which is a skin based cancer that can occur anywhere, and lymphoma and leukemia, which are lymphatic and blood system cancers, do not typically reflect cervical findings and should not be reported as Other cervical final diagnosis.

In the event that a second diagnosis of cervical cancer is reported for a woman, the program should share the necessary information with its Cancer Registry to determine if the cancer is a new primary or a recurrence. If the cervical cancer is determined to be a new primary, then it may be reported. If the cervical cancer is determined to be a recurrence, the final diagnosis should be modified to report "Other" with a description entered in the item provided for that purpose. This item should contain only final diagnosis information and not include treatment information. Examples of diagnoses that should be included are cervical polyps or vaginal intraepithelial neoplasia (VAIN) for women who do not have a cervix.

Final diagnosis is an important outcome measure for the NBCCEDP, thus it is critical that this data is complete, timely, and accurate.



WHC Abnormal Cervical Diagnostic Follow-up Form (cont.)

Question 8. Treatment Information (to be completed if cancer is diagnosed)

To specify the status of standard or conventional treatment for precancerous cervical lesions and invasive cervical carcinoma. Enter Treatment started date or date of other choices.

Status of Treatment is an important outcome measure for the NBCCEDP. It is important to know the percentage of women diagnosed with cervical dysplasia or cancer that have started treatment. It is critical that this data is complete, timely, and accurate.

Treatment started - indicate date initial treatment started	The fact that a woman is referred for standard treatment is not sufficient confirmation that treatment has been started. A woman should be classified as having started treatment only after the program has confirmed that a plan for standard treatment of the cancer or pre-cancerous lesion has been developed and started.
Treatment pending - indicate date	
Lost to follow-up - indicate date	Lost to follow-up should be reported if following a diagnosis, but prior to the initiation of treatment, a woman moves to a location beyond the program's range of treatment services (e.g. to another state or country), she can not be located (e.g. moved), or dies prior to the initiation of treatment. This should be reported when tracking efforts have been attempted in accordance with the program's written protocol but were unsuccessful.
Treatment not needed - indicate date	Treatment not needed should be reported in instances where the clinician and the woman jointly agree that treatment of the cancer would adversely affect the woman's quality of life. This may occur, for example, in cases of late or end stage cancers.

Notice of Privacy Practices

Effective April 14, 2003

HW-0320
Revised 03/07

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

- If you have any questions about this Notice, please contact the Idaho Department of Health and Welfare's Privacy Office at 208-334-6519 or by email at PrivacyOffice@dhw.idaho.gov.
- You may request a copy of this notice at any time. Copies of this notice are available at the Department of Health and Welfare offices. This notice is also available on the Department of Health and Welfare's website at <http://www.healthandwelfare.idaho.gov>

PURPOSE OF THIS NOTICE

This Notice of Privacy Practices describes how the Idaho Department of Health and Welfare (Department) handles confidential information, following state and federal requirements. All programs in the Department may share your confidential information with each other as needed to provide you benefits or services, and for normal business purposes. The Department may also share your confidential information with others outside of the Department as needed to provide you benefits or services.

We are dedicated to protecting your confidential information. We create records of the benefits or services you receive from the Department. We need these records to give you quality care and services. We also need these records to follow various local, state and federal laws.

We are required to:

- use and disclose confidential information as required by law;
- maintain the privacy of your information;
- give you this notice of our legal duties and privacy practices for your information; and
- follow the terms of the notice that is currently in effect.

This Notice of Privacy Practices does not affect your eligibility for benefits or services.

YOUR RIGHTS ABOUT YOUR CONFIDENTIAL INFORMATION

1. Right to Review and Copy

You have the right to ask to review and copy your information as allowed by law.

If you would like to ask to review and copy your information, a "[Records Request](#)" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 3 working days of receipt of your request. The Department may extend the response time to 7 additional working days if the information you have requested cannot be located or retrieved within the original 3 days. You will be sent a notification of an extension and the reason for the extension.

If you ask to receive a copy of the information, we may charge a fee. If you request 100 pages or more from our files, the fee will be 10¢ per page.

You will be told if there is information we are legally prevented from disclosing to you.

2. Right to Amend

You have the right to ask us to make changes to your information if you feel that the information we have about you is wrong or not complete.

If you would like to ask the Department to change your information, a "Request to Amend Records" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

We may deny your request if you ask us to change information that:

- Was not created by the Department;
- Is not part of the information kept by or for the Department;
- Is not part of the information which you would be allowed to review and copy; or
- We determine is correct and complete.

3. Right to Restrict Health Information Disclosures

You have the right to ask us not to share your health information for your treatment or services, or normal business purposes. You must tell us what information you do not want us to share and who we should not share it with.

If you would like to ask the Department to not share your information, a "Request to Restrict Health Information Disclosures" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

If we agree to your request, we will comply unless the information is needed to give you emergency treatment, or until you end the restriction.

4. Right to an Alternate Means of Delivery

You have the right to ask that we deliver your information to you at different mailing address. For example, you can ask that we send your information from one program to a different mailing address from other programs that you receive services or benefits from.

If you would like to ask for an alternate means of delivery for your information, a "Request for Alternate Means of Delivery" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

We will not ask you the reason for your request. Reasonable requests will be approved.

5. Right to a Report of Health Information Disclosures

You have the right to ask for a report of the disclosures of your health information. This report of disclosures will not include when we have shared your health information for treatment, payment for your treatment or normal business purposes, or the times you authorized us to share your information.

If you would like to ask for a report of your health information disclosures, a "Request to Receive a Report of Health Information Disclosures" form is available at Department offices. You must complete this form and return it to a Department office for processing. The Department will respond to your request within 10 days.

The first report you ask for and receive within a calendar year will be free of charge. For additional reports within the same calendar year, we may charge you for the costs of providing the report. We will tell you the cost and you may choose to remove or change your request at that time before any costs are charged to you.

HOW THE DEPARTMENT MAY USE AND SHARE YOUR INFORMATION

Times when your permission is not needed

- **For Treatment.** We may use your information to give you benefits, treatment or services. We may share your information with a nurse, medical professional or other personnel who are giving you treatment or services. The programs in the Department may also share your information in order to bring together the services that you may need. We also may share your information with people outside of the Department who are involved in your care, such as family members, informal or legal representatives, or others that give you services as part of your care.
- **For Payment.** We may use and share your information so that the treatment and services you receive through the Department can be paid. For example, we may need to give your medical insurance company information about the treatment or services that you received so that your medical insurance can pay for the treatment or services.
- **For Business Operations.** We may use and share your information for business operational purposes. This is necessary for the daily operation of the Department and to make sure that all of our clients receive quality care. For example, we may use your information to review our provision of treatment and services and to evaluate the performance of our staff in providing services for you.

Times when your permission is needed

- **For reasons other than Treatment, Payment or Business Operations.** There may be times when the Department may need to use and share your information for reasons other than for treatment, payment and business operations as explained above. For example, if the Department is asked for information from your employer or school that is not part of treatment, payment or business operations, the Department will ask you for a written authorization permitting us to share that information. If you give us permission to use or share your information, you may stop that permission at any time, if it is in writing. If you stop your permission, we will no longer use or share that information. You must understand that we are unable to take back any information already shared with your permission.
- **Individuals that are part of your care or payment for your care.** We may give your information to a family member, legal representative, or someone you designate who is part of your care. We may also give your information to someone who helps pay for your care. If you are unable to say yes or no to such a release, we may share such information as needed if we determine that it is in your best interest based on our professional opinion. Also, we may share your information in a disaster so that your family or legal representative can be told about your condition, status and location.

Other uses and sharing of your information that may be made without your permission

- | | |
|---|---|
| ➤ For Appointment Reminders | ➤ For Organ and Tissue Donation |
| ➤ For Treatment Alternatives | ➤ For Emergency Treatment |
| | ➤ To Prevent a Serious Threat to Health or Safety |
| ➤ As Required by Law | ➤ To Military and Veterans organizations |
| ➤ For Public Health Risks | ➤ For Health Oversight Activities |
| ➤ To Law Enforcement | ➤ For National Security and Intelligence Activities |
| ➤ For Lawsuits and Disputes | ➤ To Correctional Institutions |
| ➤ To Coroners, Medical Examiners, Funeral Directors | |

SPECIAL REQUIREMENTS

Information that has been received from a federally funded substance abuse treatment program or through the infant and toddler program will not be released without specific authorization from the individual or legal representative.

CHANGES TO THIS NOTICE

The Department has the right to change this notice. A copy of this notice is posted at our Department offices. The effective date of this notice is shown in the top right-hand corner of each page. If the Department makes any changes to this Notice of Privacy Practices, the Department will follow the terms of the notice that is currently in effect.

COMPLAINTS

If you believe your confidential information privacy rights have been violated, you may file a written complaint with the Idaho Department of Health and Welfare. All complaints turned in to the Department must be in writing on the "Privacy Complaint" form that is available at Department offices. To file a complaint with the Department, send your completed Privacy Complaint form to:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

If you believe your health information privacy rights have been violated, you may also file a complaint with the U.S Department of Health and Human Services. Your complaint must be in writing and you must name the organization that is the subject of your complaint and describe what you believe was violated. Send your written complaint to:

Region 10
Office for Civil Rights
U. S Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

For all complaints filed by e-mail send to OCRComplaint@hhs.gov

A complaint filed with either the Idaho Department of Health and Welfare or the Secretary of Health and Human Services must be filed within 180 days of when you believe the privacy violation occurred. This time limit for filing complaints may be waived for good cause.

You will not be punished or retaliated against for filing a complaint.

Aviso sobre las Prácticas de Privacidad

Fecha Vigente 14 de Abril, 2003

HW-0320S
Revisado 03/07

**ESTE AVISO DESCRIBE CÓMO SU INFORMACIÓN PUEDE SER USADA Y DIVULGADA Y
CÓMO USTED PUEDE OBTENER ACCESO A ESTA INFORMACIÓN.
POR FAVOR REVÍSELA CON CUIDADO.**

- Si usted tiene cualquier pregunta sobre este Aviso, por favor contacte a la Oficina de Privacidad del Departamento de Salud y Bienestar al 208-334-6519 ó por correo electrónico al PrivacyOffice@dhw.idaho.gov.
- Usted puede solicitar una copia de este aviso en cualquier momento. Copias de este aviso están disponibles en las oficinas del Departamento de Salud y Bienestar. Este aviso también está disponible en el sitio web del Departamento de Salud y Bienestar en <http://www.healthandwelfare.idaho.gov>

EL PROPÓSITO DE ESTE AVISO

Este Aviso sobre las Prácticas de Privacidad describe cómo el Departamento de Salud y Bienestar de Idaho (Departamento) maneja información confidencial, siguiendo los requisitos estatales y federales. Todos los programas dentro del Departamento pueden compartir información confidencial entre sí como sea necesario para proveerle beneficios o servicios y para el propósito normal de un negocio. El Departamento también puede compartir su información confidencial con otros fuera del Departamento como sea necesario para proveerle beneficios o servicios.

Nosotros estamos dedicados a proteger su información confidencial. Nosotros creamos archivos de los beneficios o servicios que usted recibe por parte del Departamento. Nosotros necesitamos estos archivos para proveerle cuidado y servicios de calidad. También necesitamos estos documentos para seguir las leyes locales, estatales y federales.

Se nos requiere de:

- usar y divulgar información confidencial como la ley lo requiere;
- mantener privada su información;
- darle este aviso de nuestros deberes legales y prácticas de privacidad para su información; y
- seguir los términos del aviso que está actualmente en efecto.

Este Aviso sobre las Prácticas de Privacidad no afecta su elegibilidad para recibir beneficios o servicios.

SUS DERECHOS SOBRE SU INFORMACIÓN CONFIDENCIAL

1. Derecho de Revisar y Copiar

Usted tiene el derecho de revisar y copiar su información como lo permita la ley.

Si a usted le gustaría revisar y copiar su información, el formulario “Records Request” (Solicitud de Documentos) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento le responderá dentro de 3 días de trabajo de cuando se recibió su petición. El Departamento puede extender el tiempo que se toma en responderle a 7 días de trabajo adicionales si la información que solicita no puede ser localizada ni recuperada dentro de los 3 días originales. Si este es el caso se le enviará un aviso de la extensión y la razón de ésta.

Si desea recibir una copia de la información, puede que exista un cobro. Si pide 100 páginas o más de nuestros archivos, el cobro puede ser de 10¢ por página.

Se le notificará si existe información que legalmente no le podemos divulgar.

2. Derecho de Corregir

Usted tiene el derecho de pedirnos que hagamos cambios a su información si cree que la información que tenemos sobre usted es errónea o no está completa.

Si le quiere pedir al Departamento que cambie su información, el formulario “Request to Amend Records” (Solicitud para Corregir Documentos) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento le responderá a su petición dentro de 10 días.

Nosotros podemos negar su petición si nos pide que cambiemos información que:

- No fue creada por el Departamento;
- No es parte de la información que es mantenida por el Departamento ni es para éste;
- No es parte de la información que se le permite revisar y copiar; o
- Nosotros determinamos que está correcta y completa.

3. Derecho de Restringir Divulgaciones de la Información sobre la Salud

Usted tiene el derecho de pedirnos que no compartamos su información sobre la salud para su tratamiento o servicios, o en el propósito normal de un negocio. Usted nos debe decir qué información no desea que compartamos y con quién no la debemos compartir.

Si usted quiere pedirle al Departamento que no comparta su información, el formulario “Request to Restrict Health Information Disclosures” (Solicitud para Restringir las Divulgaciones de la Información sobre la Salud) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento responderá a su petición dentro de 10 días.

Si otorgamos su petición, nosotros cumpliremos con su deseo a menos que la información se necesite para darle tratamiento en caso de emergencia o hasta que suspenda la restricción.

4. Derecho a una Manera Alternativa de la Entrega de Información

Usted tiene el derecho de pedir que le entreguemos su información a una dirección diferente. Por ejemplo, nos puede pedir que le enviemos su información de un programa a una dirección diferente de la de otros programas de los cuales usted recibe servicios o beneficios.

Si usted desea solicitar una manera alternativa de la entrega de su información, el formulario “Request for Alternate Means of Delivery” (Solicitud para una Manera Alternativa de Entrega) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento responderá a su petición dentro de 10 días.

Nosotros no le preguntaremos la razón de su petición. Todas las solicitudes razonables serán aprobadas.

5. Derecho a un Reporte de las Divulgaciones de la Información sobre la Salud

Usted tiene el derecho a un reporte de las divulgaciones de la información sobre su salud. Este reporte de divulgaciones no incluye las veces en que hemos compartido su información de la salud para tratamiento, pago para su tratamiento o para el propósito normal de un negocio, o las veces que nos autorizó para compartir su información.

Si usted desea solicitar un reporte de las divulgaciones de la información sobre su salud, el formulario “Request to Receive a Report of Health Information Disclosures” (Solicitud para Recibir un Reporte de las Divulgaciones de la Información sobre la Salud) está disponible en las oficinas del Departamento. Usted debe completar este formulario y regresarlo a una oficina del Departamento para procesarlo. El Departamento responderá a su petición dentro de 10 días.

El primer reporte que nos pida y que recibe en el paso de un año será libre de cobro. Para reportes adicionales dentro del mismo año, cobraremos los gastos de proveerlo. Nosotros le diremos el costo y usted puede remover o cambiar su petición en ese entonces antes de que se le cobre algo.

CÓMO EL DEPARTAMENTO PUEDE USAR Y COMPARTIR SU INFORMACIÓN

Ocasiones en donde no se necesita su permiso

- **Para Recibir Tratamiento.** Nosotros podemos usar su información para darle beneficios, tratamiento o servicios. Podemos compartir su información con una enfermera, un profesional médico u otra persona que le está dando tratamiento o servicios. Los programas en el Departamento también pueden compartir su información para coordinar servicios que tal vez necesite. Nosotros también podemos compartir su información con personas fuera del Departamento que participan en su cuidado, tales como miembros de la familia, representantes informales o legales, u otros que le pueden dar servicios como parte de su cuidado.
- **Para Recibir Pago.** Nosotros podemos usar y compartir su información para el tratamiento y los servicios que recibe por medio del Departamento puedan ser pagados. Por ejemplo, necesitamos darle a su compañía de seguro médico información sobre el tratamiento o los servicios que recibió para que su seguro médico pueda pagar el tratamiento o los servicios.
- **Para la Operación del Negocio.** Nosotros podemos usar y compartir su información con propósito de operar el negocio. Esto es necesario para la operación diaria del Departamento y para asegurarnos de que todos nuestros clientes reciben calidad de cuidado. Por ejemplo, podemos usar su información para revisar nuestra provisión de tratamiento y servicios y para evaluar el desempeño de nuestro personal cuando le provee servicios.

Ocasiones en donde se necesita su permiso

- **Por razones que no son para el tratamiento, el Pago o la Operación del Negocio.** Existen ocasiones cuando el Departamento tenga que usar y compartir su información por razones que no son para el tratamiento, el pago y la operación del negocio como se explicó arriba. Por ejemplo, si su empleador o escuela le pide información al Departamento que no es parte del tratamiento, del pago ni la operación del negocio, el Departamento le pedirá una autorización por escrito permitiéndonos compartir esa información. Si nos da permiso para usar y compartir su información, usted también puede suspender ese permiso en cualquier momento, si lo hace por escrito. Si suspende su permiso, no usaremos ni compartiremos esa información. Usted debe comprender que no podemos recuperar información que ya compartimos con su autorización.
- **Personas que son parte de su cuidado o pago por su cuidado.** Nosotros podemos darle información a un miembro de la familia, a un representante legal, o a alguien a quien usted ha designado como parte de su cuidado. También le podemos dar su información a alguien que le ayuda a pagar por su cuidado. Si usted no puede decir sí o no a dicha divulgación, podemos compartir su información como sea necesario si determinamos en nuestra opinión profesional que es para su bienestar. También, podemos compartir su información en un desastre para que su familia o representante legal esté informada sobre su condición, estado y localidad.

Otros usos de su información que pueden ser hechos sin su permiso

- | | |
|--|--|
| ➤ Para recordatorios de citas | ➤ Para donar órganos y tejido |
| ➤ Para alternativas de tratamiento | ➤ Para tratamiento de emergencia |
| ➤ Como lo requiera la ley | ➤ Para prevenir una amenaza grave a la salud y seguridad |
| ➤ Para el riesgo de la salud pública | ➤ Para organizaciones militares y de veteranos |
| ➤ Para la policía | ➤ Para actividades de supervisión de la salud |
| ➤ Para demandas y disputas | ➤ Para actividades de seguridad nacional e inteligencia |
| ➤ Para médicos forenses, examinadores médicos, directores de funerales | ➤ Para instituciones correccionales |

REQUISITOS ESPECIALES

Información que se ha recibido de un programa de tratamiento para el abuso de sustancias financiado con fondos federales o por medio del programa de bebés y niños pequeños no será divulgada sin la autorización específica de la persona o de un representante legal.

CAMBIOS A ESTE AVISO

El Departamento tiene el derecho de cambiar este aviso. Una copia de este aviso se encuentra fijado en nuestras oficinas del Departamento. La fecha de vigencia de este aviso se muestra arriba de cada página. Si el Departamento hace algún cambio a este Aviso sobre las Prácticas de Privacidad, el Departamento seguirá los términos del aviso que está actualmente en vigencia.

QUEJAS

Si usted cree que sus derechos de privacidad sobre su información confidencial han sido violados, usted puede someter una queja por escrito con el Departamento de Salud y Bienestar de Idaho. Todas las quejas que son entregadas al Departamento deben ser por escrito en el formulario de "Complaint Privacy" (Quejas de Privacidad) que está disponible en las oficinas del Departamento. Para someter una queja con el Departamento, envíe el formulario completado de Quejas de Privacidad a:

Idaho Department of Health and Welfare
Privacy Office
P.O. Box 83720
Boise, ID 83720-0036

Si usted cree que sus derechos de privacidad sobre su información de la salud han sido violados, usted también puede someter una queja con el Departamento de Salud y Servicios Humanos de los EE.UU. Su queja debe ser por escrito y debe poner el nombre de la organización la cual es el sujeto de su queja y describir lo que cree que fue violado. Envíe su queja por escrito a:

Region 10
Office for Civil Rights
U. S Department of Health and Human Services
2201 Sixth Avenue-Suite 900
Seattle, Washington 98121-1831

Para todas las quejas sometidas por correo electrónicas enviar a OCRComplaint@hhs.gov

Una queja ya sea con el Departamento de Salud y Bienestar o con el Secretario de Salud y Servicios Humanos debe ser sometida dentro de 180 días de cuando usted cree que la violación a la privacidad ocurrió. Este límite de tiempo para someter quejas puede ser suspendido con buena causa.

Usted no será castigado ni se tomarán represalias en su contra por someter una queja.

Enrollment Forms



(For LCC Use)

Client Name (Last, First, M.I.): _____ Chart #: _____

Enrollment Site: _____ Enrollment/Re-Enrollment Date: ____/____/____

(vers. 10.2008)



IDAHO DEPARTMENT OF
HEALTH & WELFARE

Idaho Women's Health Check Enrollment Form

Client Eligibility (Please verify prior to enrollment and screening. For Office Use Only)

1. U.S. Citizen? ☐ Yes ☐ No
If No - Alien ID? ☐ Yes ☐ No
2. Total number living in household (including yourself) _____
Is a spouse currently living with you? ☐ Yes ☐ No
Number of children under age 19 _____
3. Do you currently have health insurance? ☐ Yes ☐ No
Does it cover mammograms and Pap tests? ☐ Yes ☐ No
Does the amount of your deductible prevent you from getting a mammogram or Pap test? ☐ Yes ☐ No
Type of health insurance:
☐ Private
Name of Company: _____
☐ Medicaid
☐ Medicare—Part A Only

4. Total household income (gross) before taxes:
\$ _____ yearly or \$ _____ monthly
5. Age: ☐ 50-64 (eligible for breast and cervical screening)
☐ 40-49 (eligible for cervical screening)
☐ 30+ * (limited enrollment—client symptomatic for cancer)
*limited enrollment authorization form attached

This client meets all enrollment requirements.

- ____ Citizen/eligible alien
(alien must live in United States
at least 5 continuous years)
____ No insurance coverage
____ Income (use current table)
____ Age

Eligibility verified by: _____

1. Client Information (required)

Last Name: _____ First: _____ Middle: _____

Maiden Name (if applicable): _____ Date of Birth: ____/____/____

U.S. Citizen? ☐ Yes ☐ No Place of Birth (State): _____

Social Security #: _____ - _____ - _____ OR Alien ID #: _____ Issue Date: ____/____/____
Mo./Year

Home Mailing Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home/Cell Phone: (____) _____ - _____ Work Phone: (____) _____ - _____

2. Ethnicity and Race (all answers required)

Ethnicity: (check one)

- ☐ Non-Hispanic
☐ Hispanic
☐ Unknown

What race do you consider yourself? (check all that apply)

- ☐ White
☐ Black or African American
☐ Asian
☐ Pacific Islander or Native Hawaiian
☐ American Indian or Alaska Native
☐ Unknown

What language do you prefer for medical information?

(check one)

- ☐ English
☐ Spanish

3. Emergency Contact

Someone we may contact in case we cannot reach you:

First Name: _____

Last Name: _____

Phone: (____) _____ - _____

4. How did you hear about this program? (check all that apply)

- ☐ Health Care Provider ☐ American Cancer Society
☐ Community Event/Health Fair ☐ Church Bulletin
☐ Friend/Relative ☐ Foodbank
☐ Health Department ☐ Newspaper
☐ Radio ☐ Reminder Notice
☐ Television ☐ Web
☐ Other _____

Please check all that apply. Knowingly providing false information may result in criminal, civil or administrative action.

- ☐ The information I have provided on this form is correct.
☐ I wish to start/continue receiving services through Idaho's Women's Health Check.
☐ I am a U.S. Citizen. (*Original birth certificate or documentation of citizenship will be required should you need treatment.)
OR ☐ I have an Alien ID and have lived in the United States for at least 5 years. (Alien ID card will be required should you need treatment.)

Client Signature: _____ Date: ____/____/____



(For Office Use Only)

Enrollment Site: _____ Local Coordinating Contractor _____

Women's Health Check Enrollment Form (page 2) Program Consent and Information Release



Women's Health Check involves a cooperative effort between clinics, doctors, mammography facilities, laboratories, the Idaho Department of Health & Welfare, and the Centers for Disease Control and Prevention (CDC). The purpose of this program is to encourage screening for breast and cervical cancer for women who are US Citizens or eligible non-citizens with low income who have no other way to pay for screening tests (no insurance coverage for these tests, no Medicare or Medicaid). The purpose of screening is to detect cancer in its earliest stage so that it can be treated or prevented. Screening for breast cancer involves a breast examination and a mammogram. Screening for cervical cancer involves a pelvic examination and a Pap test. If needed, most diagnostic tests will be available at no cost to you. Should you need treatment for cancer, you may qualify for treatment through the BCC Medicaid Program.

Authorization to Release Protected Health Information:

- ☐ I have read and understand the program description (above) of the Idaho Women's Health Check Program (WHC), understand that I am eligible for the program, and hereby consent to receive the health services as indicated above.
- ☐ By agreeing to take part in this program, I give permission to any and all of my doctors, clinics, Mammography facilities, and/or hospitals to provide all information concerning my Pap tests, breast exams, mammograms and any related diagnostic and treatment procedures to the WHC program. Case managers employed by the program may contact me for purpose of gathering information to help me access important tests and exams for adequate follow-up of abnormal test results.
- ☐ I understand that any information I give to WHC and participating providers is confidential. This means that WHC will not disclose or share my information, except for the minimum necessary to administer the Program described above. Reports, which result from this Program, will not use my name or any other identifying information.
- ☐ By signing this form, I am stating that I agree to, and understand, the terms of the program described above. I am also stating that the information I provided on the Enrollment Form is true. I understand that my participation in this Program is voluntary, and that I can drop out of the Program at any time.
- ☐ I understand that if I should be diagnosed with cancer or pre-cancerous conditions I may qualify for treatment through the BCC Medicaid program, and agree to release my information to Medicaid to determine if I am eligible for treatment.

- ☐ I have been offered the opportunity to read the Idaho Department of Health and Welfare's Notice of Privacy Practices (also available at www.healthandwelfare.idaho.gov).
- ☐ I would like Women's Health Check to send me a copy of the Idaho Department of Health and Welfare's Notice of Privacy Practices.

Signature

Print Name

____/____/____
Date



(Para uso de LCC)

Nombre de la cliente (Apellido, Nombre, Inicial): _____ Expediente #: _____
Sitio de inscripción: _____ Fecha de inscripción/reinscripción: ____/____/____

Formulario de inscripción para una revisión para mujeres (Women's Health Check de Idaho)



Elegibilidad de la cliente *(Verifique antes de la inscripción y evaluación inicial. Exclusivo para uso de la oficina)*

1. ¿Es ciudadana estadounidense? ☐ Sí ☐ No
Si es No, ¿tiene ID como extranjera? ☐ Sí ☐ No
2. Total de personas que viven en la casa (incluyéndose) _____
¿Su cónyuge vive con usted? ☐ Sí ☐ No
Número de hijos menores de 19 años _____
3. ¿Tiene actualmente seguro médico privado? ☐ Sí ☐ No
¿Cubre mamogramas y examen de Papanicolaou? ☐ Sí ☐ No
¿La cantidad del deducible no le permite hacerse un mamograma o examen de Papanicolaou? ☐ Sí ☐ No
Tipo de seguro médico:
☐ Privado
Nombre de la compañía: _____
☐ Medicaid
☐ Medicare— sólo Parte A

4. Ingreso total de la familia (bruto) antes de impuestos:
\$ _____ al año o \$ _____ mensual
5. Edad: ☐ 50-64 (elegible para evaluación mamaria y cervicouterina)
☐ 40-49 (elegible para evaluación cervicouterina)
☐ 30+ * (inscripción limitada: cliente sintomática de cáncer)
*se anexa el formulario de autorización de inscripción limitada

Esta cliente cumple con los requisitos de inscripción.

_____ Ciudadana/extranjera elegible
(la extranjero debe vivir al menos 5 años
seguidos en Estados Unidos)

_____ Sin cobertura de seguro

_____ Ingreso (use tabla actual)

_____ Edad

Elegibilidad verificada por: _____

1. Información de la cliente *(requerida)*

Apellido: _____ Nombre: _____ Inicial: _____
Apellido de soltera (si corresponde): _____ Fecha de nacimiento: ____/____/____
¿Es ciudadana estadounidense? ☐ Sí ☐ No Lugar de nacimiento (Estado): _____
Seguro social #: _____ O ID de extranjero #: _____ Fecha de expedición: ____/____
Dirección postal particular: _____
Ciudad: _____ Condado: _____ Estado: _____ Código postal: _____
Teléfono casa/celular: (____) _____-____ Teléfono oficina: (____) _____-____

2. Origen étnico y raza *(se requieren todas las respuestas)*

Origen étnico: *(marque uno)*

☐ No hispano

☐ Hispano

☐ Desconocido

¿De qué raza se considera? *(marque todas las que correspondan)*

☐ Blanca

☐ Negra o afroamericana

☐ Asiática

☐ Isleña del Pacífico o Nativo de Hawai

☐ Indio americana o Nativo de Alaska

☐ Desconocido

¿En qué idioma prefiere la información médica?
(marque uno)

☐ Inglés

☐ Español

3. Contacto de emergencia

Persona a la que podamos llamar en caso de no localizarla:

Nombre: _____

Apellido: _____

Teléfono: (____) _____-____

4. ¿Cómo se enteró de este programa? *(marque todas las respuestas que correspondan)*

☐ Proveedor de cuidado médico

☐ Evento en comunidad/Feria de salud

☐ Amistad/Familiar

☐ Departamento de salud

☐ Radio

☐ Televisión

☐ Otro _____

☐ Sociedad Americana contra el Cáncer

☐ Boletín en la iglesia

☐ Banco de comida

☐ Periódico

☐ Recordatorio

☐ Web

Página 1 de 2

Marque todas las respuestas que correspondan bajo conocimientos de que proporcionar información falsa puede dar como resultado medidas legales, civiles o administrativas.

☐ La información que he proporcionado en este formulario está correcta.

☐ Deseo empezar/continuar con el servicio a través de Women's Health Check de Idaho

☐ Soy ciudadana estadounidense. *(Si necesita el tratamiento deberá presentar el acta de nacimiento o documento de ciudadanía original.)*

O ☐ Tengo ID como extranjera y he vivido en Estados Unidos al menos 5 años. *(Si necesita tratamiento, deberá presentar su tarjeta de ID como extranjera.)*

Firma de la cliente: _____ Fecha: ____/____/____



(Exclusivo para uso de la oficina)

Centro de inscripción: _____ Contratista coordinador local _____

Formulario de inscripción para una revisión para mujeres (Women's Health Check de Idaho) (página 2) Consentimiento del programa y difusión de información

Women's Health Check es una iniciativa de cooperación entre clínicas, doctores, centros para tomas de mamogramas, laboratorios del Departamento de Salud y Bienestar de Idaho y los Centros para el Control y Prevención de Enfermedades (CDC). El objetivo del programa es alentar la evaluación de cáncer de pecho y cervicouterino en mujeres que son ciudadanas estadounidenses o que, sin ser ciudadanas, son elegibles, con ingresos bajos y que no tienen otro medio de pagar los exámenes de evaluación (sin cobertura de seguro para estos exámenes, sin Medicare ni Medicaid). El objetivo de la evaluación es detectar cáncer en sus primeras etapas, de modo que pueda tratarse o prevenirse. La evaluación de cáncer de pecho comprende un examen de pecho y una mamograma. La evaluación de cáncer cervicouterino comprende un examen pélvico y un Papanicolaou. Si se requiere, usted dispone de la mayoría de los exámenes de diagnóstico gratuitamente. En caso de que necesitara tratamiento para cáncer, es posible que tenga derecho a recibir el tratamiento a través del Programa BCC de Medicaid.

Autorización para divulgar información de salud protegida:

- ☐ He leído y entendido la descripción del programa (arriba) del Programa Women's Health Check (WHC) de Idaho. Entiendo que tengo derecho al programa y por la presente acepto recibir los servicios de salud como se indica arriba.
- ☐ Al aceptar tomar parte en este programa, doy mi permiso a todos mis doctores, clínicas, centros para tomas de mamograma y hospitales a que proporcionen toda la información relativa a mis exámenes de Papanicolaou, exámenes de pecho, mamogramas y cualquier procedimientos de diagnóstico y tratamiento al programa WHC. Los gerentes de caso que trabajan en el programa pueden ponerse en contacto conmigo con el propósito de obtener información para ayudarme a tener acceso a pruebas y exámenes importantes para el seguimiento adecuado de resultados de exámenes anormales.
- ☐ Entiendo que toda información que dé a WHC y a los proveedores participantes es confidencial. Esto significa que WHC no revelará ni comunicará mi información, salvo el mínimo necesario para administrar el Programa descrito arriba. Los informes que se generen en este programa no llevarán mi nombre ni ninguna información que me identifique.
- ☐ Al firmar este formulario, declaro que acepto y entiendo los términos del programa descrito arriba. También declaro que la información que asiente en el Formulario de Inscripción es cierta. Entiendo que mi participación en este Programa es voluntaria y que puedo abandonarlo en cualquier momento.
- ☐ Entiendo que si fuera diagnosticada con cáncer o condiciones precancerosas, puedo calificar para el tratamiento a través del programa BCC de Medicaid y acepto entregar mi información a Medicaid para determinar si tengo derecho al tratamiento.
- ☐ Se me dio la oportunidad de leer el Aviso de Prácticas de Privacidad del Departamento de Salud y Bienestar de Idaho (se encuentra también en www.healthandwelfare.idaho.gov). Quisiera que Women's Health Check me enviara un ejemplar del Aviso de Prácticas de Privacidad del Departamento de Salud y Bienestar de Idaho.

Firma

Nombre con letra de molde

_____/_____/_____
Fecha

(Exclusivo para uso de la oficina)

Centro de inscripción: _____ Contratista coordinador local _____

Women's Health Check Intake Assessment

Services and Responsibilities

vers. (03.21.2008)



Name/Nombre: _____ Date/Fecha: (____/____/____)
Last (Print) / Apellido (Letra de molde) First/Primer Nombre MI/ Inicial del Medio Nombre Month Mes Day Día Year Año

Services Covered

- **Clinical Breast Exam/Mammogram** – Yearly
- **Pap Test** – yearly for conventional pap, and every two years for a liquid based pap test
- **Diagnostic Tests** – if needed
- **Treatment** – if needed and you must meet eligibility requirements

Tests not related to breast or cervical cancer screening or not authorized by Women's Health Check will not be covered.

Your Responsibility

- Having a mammogram, clinical breast exam, and Pap test yearly or as recommended
- Having additional diagnostic tests if any abnormalities are found
- Keeping appointments for screening and follow-up services

A health provider may ask for diagnostic tests that are not covered by Women's Health Check. Please check with your health care provider to make other arrangements for the tests or services not covered by this program.

 **Client Initial** _____

Is there anything that might prevent you from keeping your appointments?

- ☐ Transportation/Travel distance/Work schedule
- ☐ Lack of money/Child or family care
- ☐ Need more information/Questions about screening
- ☐ Other: (translation/making appointments)

Appointment Preferences: ☐ a.m. ☐ p.m.

☐ Mon ☐ Tues ☐ Wed ☐ Thurs ☐ Fri

Scheduled Appointments:

☐ Pap _____
date

☐ Clinical Breast Exam _____
date

☐ Mammogram _____
date

Servicios Incluidos

- **Examen Clínico del Seno/Mamografía** – Anual
- **Examen del Papanicolau** – Cada año para una prueba convencional y cada dos años para una prueba de base líquida
- **Pruebas de Diagnóstico** - según se necesiten
- **Tratamiento** - según se necesite y si llena los requisitos de elegibilidad

Las pruebas que no están relacionadas a las evaluaciones para el cáncer del seno o al cáncer cervical o que no han sido autorizadas por Chequeo de la Salud para Mujeres

(Women's Health Check) no serán cubiertas.

Responsabilidad de la Cliente

- Hacerse un mamografía, un examen clínico del seno, y una prueba del Papanicolau anual o según se recomiende
- Hacerse pruebas adicionales de diagnóstico si se encuentran anomalías
- Mantener las citas para los servicios de chequeo y de reevaluación

De vez en cuando un proveedor del cuidado de la salud pide pruebas de diagnóstico que no son cubiertas por el Chequeo de la Salud para Mujeres (Women's Health Check). Por favor averigüe con su proveedor del cuidado de la salud para hacer otros arreglos sobre las pruebas o servicios que no cubre el programa.

 **Iniciales de la Cliente** _____

¿Hay algo que le prevenga de asistir a sus citas?

- ☐ Transportación/Distancia del viaje/Horario de trabajo
- ☐ Falta de dinero/Cuidado de niños o de familia
- ☐ Necesita más información/Preguntas sobre los procesos de evaluación
- ☐ Otro: Necesito ayuda haciendo citas/Interpretación (idioma)

Preferencias Citas: ☐ a.m. ☐ p.m.

☐ Lunes ☐ Martes ☐ Miércoles ☐ Jueves ☐ Viernes

Citas Fijadas: ☐ Papanicolau _____
fecha

☐ Examen Clínico del Seno _____
fecha

☐ Mamografía _____
fecha

Take your Women's Health Check Identification Card to your appointment.

 **Esté segura de llevar con usted a la cita su tarjeta de identificación del Chequeo de la Salud para Mujeres.** 

If at any time you do not wish to participate in Women's Health Check, you may cancel your enrollment by contacting your local Women's Health Check office and letting us know.

Si en cualquier momento no desea participar en el programa del Chequeo de la Salud para Mujeres (Women's Health Check), llame a nuestra oficina para cancelar su inscripción.



Limited Enrollment Approval

(vers. 2007)

- Uninsured women age 40 – 49 at high risk and/or symptomatic for breast cancer
- Uninsured women age 30-39 symptomatic for breast cancer
- Uninsured women age 30 - 39 at high risk and/or symptomatic for cervical cancer

Client Name: _____ Age: _____ D.O.B. _____

Enrollment based on the following clinical symptoms or risk factors for breast cancer:

Clinical Findings:

(Uninsured women **age 30-49** can be enrolled if symptomatic)

- ☐ unilateral ☐ irregular boundaries
- ☐ non-moveable ☐ tender ☐ non-tender
- ☐ Discharge ☐ Scaling
- ☐ Dimpling or retraction ☐ Other _____
- ☐ Confirmed by CBE, performed by _____
- ☐ Confirmed by mammogram

Additional Information: ☐ Post menopausal

Risk Factors:

(Uninsured women **age 40 – 49** can be enrolled if the following applies)

- ☐ Breast cancer hx: Self _____ Age at onset: _____
- ☐ Breast biopsy hx: Number of biopsies: _____
- ☐ Result of atypical hyperplasia
- ☐ Previous chest irradiation

Enrollment based on the following clinical symptoms or risk factors for cervical cancer:
(Uninsured women **age 30 – 39** can be enrolled based on having at least one risk factor and/or symptoms for cervical cancer)

Clinical Findings:

☐ Previous abnormal pap/cervical cytology/colposcopy/or biopsy

Date of prior cytology and results if known _____

Date of colposcopy/ biopsy and results if known _____

☐ HPV Positive Date _____

☐ Hx of other sexually transmitted infections

☐ Abnormal bleeding ☐ Lesion – size _____

☐ Prior LEEP/Cone ☐ Cervical Erosion

Additional Clinical information (i.e. pertinent clinical history, physical findings, gynecological surgery)

Risk Factors:

☐ Never or rarely screened:

(Defined by Centers for Disease Control as a risk factor)

☐ Has never had a Pap smear ☐ 5 years or more since last Pap smear

☐ Hx of reproductive cancer

☐ Tobacco use: Number of years _____

Based on information documented above, this client is at high risk and/or symptomatic for breast and/or cervical cancer. Client is not currently undergoing diagnostic workup. Enrollment in Women's Health Check for breast and/or cervical cancer screening is recommended.

Clinician: _____ Title: _____ Phone: _____ Date: _____

Contacting Clinic: _____

Submit with Enrollment Form



(For Office Use Only)

Client Name (Last, First, M.I.): _____ Date of Birth: (____/____/____)

Screening Facility: _____ Visit Date: ____/____/____

(vers. 10.2008)

Idaho Women's Health Check Screening Form



Breast Screening (ages 50-64)

☐ Breast record only, cervical services not done

History

1. Prior Mammogram?

- ☐ Yes.....(If yes, date ____/____/____)
☐ No
☐ Unknown

2. Breast Symptoms?

- ☐ Yes
☐ No
☐ Unknown

3. Indications for today's mammogram:

(check only one)

- ☐ Routine screening mammogram (screening)
☐ Initial mammogram to evaluate additional symptoms, abnormal CBE result, or follow-up from a previous abnormal mammogram (diagnostic)
☐ Referred into the program for diagnostic evaluation
Date of initial mammogram (already completed) ____/____/____
Date of referral into program ____/____/____
Result (BI-RADS): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 0
☐ Mammogram not done. Patient only received CBE, or proceeded directly for other imaging or diagnostic work-up

4. Clinical Breast Exam (CBE) Results

Date: (____/____/____)

Provider: _____

(check only one)

- ☐ Normal/Benign/Fibrocystic
☐ Discrete palpable mass (suspicious for cancer)*
☐ Nipple/areolar scaliness*
☐ Bloody or serous nipple discharge*
☐ Skin dimpling or retraction*
☐ Refused/Not done at this visit, but needed
☐ Not needed, normal CBE in past 12 mos.

***Diagnostic work-up required**
(Use WHC Diagnostic and Follow-up Forms)

CBE funded by WHC? ☐ Yes ☐ No, Pd by other

5. Mammogram Results

☐ Conventional ☐ Digital

Date: (____/____/____)

Facility: _____

(check only one)

- ☐ 1 Negative
☐ 2 Benign
☐ 3 Probably Benign—STFU required
☐ 4 Suspicious Abnormality (consider biopsy)*
☐ 5 Highly Suggestive of Malignancy*
☐ 0 Incomplete—need additional imaging*

***Diagnostic work-up required**
(Use WHC Diagnostic and Follow-up Forms)

Film Comparison to evaluate Assessment Incomplete? ☐ Yes ☐ No

Mammogram funded by WHC? ☐ Yes ☐ No, Pd by other

6. Breast Cycle Outcome

- ☐ Routine Annual Screening
☐ Diagnostic Work-Up Planned
☐ Short term Follow-up Planned

Recommendation:

Cervical Screening (ages 40-64)

☐ Cervical record only, breast services not done

History

1. Prior Pap test?

- ☐ Yes.....(If yes, date ____/____/____)
☐ No

2. Hysterectomy for Cervical Neoplasia/Cervical Cancer?

- ☐ Yes
☐ No

3. Indications for today's Pap test:

(check only one)

- ☐ Routine Pap test (screening)
☐ To evaluate additional symptoms, abnormal test result, or follow-up from previous abnormal Pap test result
☐ Referred into the program as a diagnostic evaluation;
Date of referral into program ____/____/____
Pap test Result _____
☐ Pap test not done. Previous result ASC-US. Patient proceeded directly for HPV test

4. Pelvic Exam Result

Date: (____/____/____)

Provider: _____

- ☐ Normal
☐ Abnormal—NOT suspicious for cervical cancer
☐ Abnormal—suspicious for cervical cancer*

***Diagnostic work-up required**

5. Pap test results

Date: (____/____/____)

Facility: _____

(check only one)

- ☐ Negative for intraepithelial lesion or malignancy
☐ Atypical squamous cells of undetermined significance (ASC-US)
☐ Low grade squamous cells intraepithelial lesion (LSIL)*
☐ Atypical squamous cells, can not exclude high grade (ASC-H)*
☐ High grade squamous intraepithelial lesion (HSIL)*
☐ Squamous Cell Carcinoma*
☐ Abnormal Glandular Cells (AGC)*
☐ Endocervical adenocarcinoma in situ (AIS)*
☐ Adenocarcinoma*
☐ Other _____

***Diagnostic work-up required**
(Use WHC Diagnostic and Follow-up Forms)

Pap test funded by WHC? ☐ Yes ☐ No, Pd by other

Specimen Adequacy: ☐ Satisfactory ☐ Unsatisfactory

Specimen Type: ☐ Conventional ☐ Liquid Based

6. HPV Test Result

Date: (____/____/____)

HPV Result: ☐ Negative ☐ Positive ☐ Unknown

Test funded by WHC? ☐ Yes ☐ No, Pd by other

7. Cervical Cycle Outcome

- ☐ Routine Screening
☐ Diagnostic Work-Up Planned
☐ Short term Follow-up Planned

Recommendation:

***Diagnostic work-up required** (Use WHC Diagnostic and Follow-up Forms)

Women's Health Check Waiting List _____ (LCC)

- Low income, with no other resource for payment, such as insurance
- Women age 50-64 (screening mammogram, clinical breast exam)
- Women age 40-64 (Pap test, pelvic exam)
- Enrollment for women age 30+ presenting with symptoms or high risk limited to 25% of total new enrollment
- Must enroll screening priority prior to other referrals

Priority Age Screening Waiting List					
Date	Age	Contact #	Breast and/or Cervical	Comments	Date Enrolled
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					

[illegible]

SAMPLE
Women's Health Check Waiting List
_____ (Site and LCC)

Women's Health Check is a breast and cervical cancer screening program, funded through CDC to screen priority populations:

- **Low income with no other resource for health care reimbursement (such as insurance)**
 - Enrollment for uninsured women age 30+ presenting with symptoms limited to 25% of total new enrollment
 - Must enroll screening priority prior to other referrals
- **Women age 50-64 (screening mammogram, CBE)**
 - **Women age 40-64 (Pap test, pelvic exam)**

Priority Age Screening Waiting List

Date	Age	Name and Contact #	Breast &/or Cervical	Comments	Date Enrolled
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					
After 3 Enrolled from priority population, one age 30+ referral may be enrolled					

Waiting List for Women with Symptoms < Priority Age

[illegible]

Screening and Diagnosis Forms

SCREENING AND DIAGNOSIS FORMS

Women's Health Check forms included in this section may be used to collect accurate and complete information to send to Local Coordinating Contractor (LCC) for data entry into WHCRT.

Other reports or means of communicating accurate and detailed results may be used by the LCC.



(For Office Use Only)

Client Name (Last, First, M.I.): _____ Date of Birth: ____/____/____

Facility: _____

(vers. 10.2008)

Idaho Women's Health Check Abnormal Breast Diagnostic Follow-up



1. Breast Imaging

Additional Mammographic Views? ☐ Yes ☐ No

Ultrasound? ☐ Yes ☐ No

Results (check only one)

- ☐ 1 Negative
☐ 2 Benign
☐ 3 Probably Benign—STFU required
☐ 4 Suspicious Abnormality (consider biopsy)
☐ 5 Highly Suggestive of Malignancy
☐ 0 Incomplete

Date

(____/____/____)

Facility:

Recommended follow-up covered by WHC:

- ☐ Follow Routine Screening Schedule
☐ Short Term Follow-up _____
☐ Surgical Consultation
☐ Fine Needle Aspiration
☐ Biopsy
☐ CBE by Consult

1a. Final Imaging Outcome: (check only one) Date: (____/____/____)

- ☐ BI-RADS 1 ☐ BI-RADS 2 ☐ BI-RADS 3 ☐
☐ BI-RADS 4 ☐ BI-RADS 5 Unsatisfac- ☐ tory
☐ Additional Imaging Pending

2. Surgical Consultation

☐ Yes ☐ No

Consult Outcome

(check only one)

- ☐ No intervention at this time
☐ Core Biopsy
☐ Fine Needle Aspiration

Date:

(____/____/____)

Provider:

Recommended follow-up covered by WHC:

- ☐ Follow Routine Screening Schedule
☐ Short Term Follow-up _____
☐ Additional Mammographic Views
☐ Ultrasound
☐ Fine Needle Aspiration
☐ Biopsy

3. Consultant-Repeat CBE

☐ Yes ☐ No

Consult/CBE Results (check only one)

- ☐ Normal/Benign/Fibrocystic
☐ Discrete palpable mass (suspicious for cancer)
☐ Nipple/areolar scaliness
☐ Bloody or serous nipple discharge
☐ Skin dimpling or retraction

Date:

(____/____/____)

Provider:

Recommended follow-up covered by WHC:

- ☐ Follow Routine Screening Schedule
☐ Short Term Follow-up _____
☐ Additional Mammographic Views
☐ Ultrasound
☐ Surgical Consultation
☐ Fine Needle Aspiration
☐ Biopsy

4. Fine Needle/Cyst Aspiration

☐ Yes ☐ No

Results

(check only one)

- ☐ No fluid/tissue obtained
☐ Not suspicious for cancer
☐ Suspicious for cancer

Date:

(____/____/____)

Provider:

Recommended follow-up covered by WHC:

- ☐ Follow Routine Screening Schedule
☐ Short Term Follow-up _____
☐ Additional Mammographic Views
☐ Ultrasound
☐ Surgical Consultation
☐ Biopsy
☐ CBE by Consult

5. Tissue Biopsy/Lumpectomy

☐ Yes ☐ No

Results (check only one)

- ☐ Normal Breast Tissue
☐ Ductal Carcinoma *in situ*
☐ Lobular Carcinoma *in situ*
☐ Invasive Breast Cancer
☐ Atypical Ductal Hyperplasia (ADH)
☐ Hyperplasia
☐ Other benign changes

Date:

(____/____/____)

Provider:

Recommended follow-up covered by WHC:

- ☐ Follow Routine Screening Schedule
☐ Short Term Follow-up _____
☐ Obtain Treatment—apply for BCC Medicaid separately

6. Were any other breast procedures performed? ☐ Yes ☐ No

7. Were any imaging or diagnostic procedures funded by Women's Health Check? ☐ Yes ☐ No

8. Diagnostic Work-up Status

(check only one)

- ☐ Pending
☐ Work-up complete
☐ Lost to follow-up
☐ Work-up refused

Additional Comments:

9. Final Diagnosis

Date: ____/____/____

(check only one)

- ☐ Breast Cancer not diagnosed
☐ Ductal Carcinoma *in situ*
☐ Lobular Carcinoma *in situ*
☐ Invasive Breast Cancer
☐ Other _____

Additional Comments:

10. Treatment Information

(to be completed if cancer is diagnosed)

☐ Treatment started.....Date: ____/____/____

☐ Treatment pending*

☐ Lost to follow-up*

☐ Treatment not needed*

*Date: ____/____/____

Additional Comments:



(For Office Use Only)

Client Name (Last, First, M.I.): _____ Date of Birth: ____/____/____

Facility: _____

(vers. 10.2008)



Idaho Women's Health Check

Abnormal Cervical Diagnostic Follow-up

IDAHO DEPARTMENT OF HEALTH & WELFARE

1. Gynecologic consultation

☐ Yes ☐ No

Date:

(____/____/____)

Provider:

Consult Outcome

(check only one)

- ☐ Normal/Benign/Inflammation
☐ Other abnormality
☐ Suspicious for cervical cancer

Recommended follow-up covered by WHC:

- ☐ Follow Routine Screening
☐ Short Term Follow-up _____
☐ Colposcopy
☐ Diagnostic Cone—state approval required
☐ HPV Test
☐ Diagnostic LEEP—state approval required
☐ Other Biopsy
☐ Repeat Pap test Immediately

2. Colposcopy

☐ Yes ☐ No

Date:

(____/____/____)

Provider:

(check only one)

- ☐ With Biopsy
☐ With biopsy and ECC
☐ Without biopsy

Results (check only one)

- ☐ Negative
☐ Other nonmalignant abn (HPV, Condyloma, Atypia)
☐ No visible lesion, no biopsy done
☐ CIN 1
☐ CIN 2
☐ CIN 3/CIS
☐ Invasive Carcinoma
☐ Adenocarcinoma

Recommended follow-up covered by WHC:

- ☐ Follow Routine Screening
☐ Short Term Follow-up _____
☐ Colposcopy
☐ Diagnostic Cone—state approval required
☐ Gynecologic Consultation
☐ HPV Test
☐ Diagnostic LEEP—state approval required
☐ Other Biopsy
☐ Repeat Pap test Immediately

☐ Obtain Treatment—apply for BCC Medicaid separately

3. Other Biopsy Options

Endocervical Curettage alone (ECC)

☐ Yes ☐ No

Loop Electrosurgical Excision Procedure (LEEP)*

☐ Yes ☐ No

Cold Knife Cone (CKC)*

☐ Yes ☐ No

*State approval needed. Contact State office.

Results (check only one)

- ☐ Negative
☐ Other nonmalignant abn (HPV, Condyloma, Atypia)
☐ No visible lesion, no biopsy done
☐ CIN 1
☐ CIN 2
☐ CIN 3/CIS
☐ Invasive Carcinoma
☐ Adenocarcinoma

Date:

(____/____/____)

Provider:

Recommended follow-up covered by WHC:

- ☐ Follow Routine Screening
☐ Short Term Follow-up _____
☐ Colposcopy
☐ Diagnostic Cone—state approval required
☐ Gynecologic Consultation
☐ HPV Test
☐ Diagnostic LEEP—state approval required
☐ Other Biopsy
☐ Repeat Pap test Immediately

☐ Obtain Treatment—apply for BCC Medicaid separately

4. Were any other cervical procedures performed?

☐ Yes _____ ☐ No

5. Were any diagnostic procedures funded by Women's Health Check?

☐ Yes ☐ No

6. Diagnostic Work-up Status

(check only one)

- ☐ Pending
☐ Work-up complete
☐ Lost to follow-up
☐ Work-up refused

Additional Comments:

7. Final Diagnosis

Date (____/____/____)

(check only one)

- ☐ Normal/Benign/Inflammation
☐ HPV/Condylomata/Atypia
☐ CIN 1/mild dysplasia
☐ CIN 2/moderate dysplasia
☐ CIN 3/severe dysplasia/carcinoma *in situ*
☐ Invasive Carcinoma
☐ Adenocarcinoma
☐ Other _____

Additional Comments:

8. Treatment Information

(to be completed if cancer is diagnosed)

☐ Treatment started.....Date: ____/____/____

- ☐ Treatment pending*
☐ Lost to follow-up*
☐ Treatment not needed* } *Date: ____/____/____

Additional Comments:

Claims Forms

PLEASE
DO NOT
STAPLE
IN THIS
AREA



CARRIER

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> CHAMPUS <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN (SSN or ID) <input type="checkbox"/> FECA BLK LUNG (SSN) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID)						1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)																	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)						3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>						4. INSURED'S NAME (Last Name, First Name, Middle Initial)											
5. PATIENT'S ADDRESS (No., Street)						6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>						7. INSURED'S ADDRESS (No., Street)											
CITY						STATE						CITY						STATE					
ZIP CODE						TELEPHONE (Include Area Code) ()						ZIP CODE						TELEPHONE (INCLUDE AREA CODE) ()					
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)						10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (CURRENT OR PREVIOUS) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="checkbox"/> c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO						11. INSURED'S POLICY GROUP OR FECA NUMBER											
a. OTHER INSURED'S POLICY OR GROUP NUMBER												a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>											
b. OTHER INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>												b. EMPLOYER'S NAME OR SCHOOL NAME											
c. EMPLOYER'S NAME OR SCHOOL NAME												c. INSURANCE PLAN NAME OR PROGRAM NAME											
d. INSURANCE PLAN NAME OR PROGRAM NAME						10d. RESERVED FOR LOCAL USE						d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, return to and complete item 9 a-d.											
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____												13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____											
14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)						15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY						16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY											
17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE						17a. I.D. NUMBER OF REFERRING PHYSICIAN						18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY											
19. RESERVED FOR LOCAL USE												20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO											
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE) 1. _____ 3. _____ 2. _____ 4. _____												22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.											
23. PRIOR AUTHORIZATION NUMBER																							
24. A DATE(S) OF SERVICE From To B Place of Service C Type of Service D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCCPS MODIFIER E DIAGNOSIS CODE F \$ CHARGES G DAYS OR UNITS H EPSDT Family Plan I EMG J COB K RESERVED FOR LOCAL USE																							
1																							
2																							
3																							
4																							
5																							
6																							
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>						26. PATIENT'S ACCOUNT NO.						27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO											
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____						32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)						33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE # PIN# _____ GRP# _____											

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

BECAUSE THIS FORM IS USED BY VARIOUS GOVERNMENT AND PRIVATE HEALTH PROGRAMS, SEE SEPARATE INSTRUCTIONS ISSUED BY APPLICABLE PROGRAMS.

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

REFERS TO GOVERNMENT PROGRAMS ONLY

MEDICARE AND CHAMPUS PAYMENTS: A patient's signature requests that payment be made and authorizes release of any information necessary to process the claim and certifies that the information provided in Blocks 1 through 12 is true, accurate and complete. In the case of a Medicare claim, the patient's signature authorizes any entity to release to Medicare medical and nonmedical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, worker's compensation or other insurance which is responsible to pay for the services for which the Medicare claim is made. See 42 CFR 411.24(a). If item 9 is completed, the patient's signature authorizes release of the information to the health plan or agency shown. In Medicare assigned or CHAMPUS participation cases, the physician agrees to accept the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary as the full charge, and the patient is responsible only for the deductible, coinsurance and noncovered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier or CHAMPUS fiscal intermediary if this is less than the charge submitted. CHAMPUS is not a health insurance program but makes payment for health benefits provided through certain affiliations with the Uniformed Services. Information on the patient's sponsor should be provided in those items captioned in "Insured"; i.e., items 1a, 4, 6, 7, 9, and 11.

BLACK LUNG AND FECA CLAIMS

The provider agrees to accept the amount paid by the Government as payment in full. See Black Lung and FECA instructions regarding required procedure and diagnosis coding systems.

SIGNATURE OF PHYSICIAN OR SUPPLIER (MEDICARE, CHAMPUS, FECA AND BLACK LUNG)

I certify that the services shown on this form were medically indicated and necessary for the health of the patient and were personally furnished by me or were furnished incident to my professional service by my employee under my immediate personal supervision, except as otherwise expressly permitted by Medicare or CHAMPUS regulations.

For services to be considered as "incident" to a physician's professional service, 1) they must be rendered under the physician's immediate personal supervision by his/her employee, 2) they must be an integral, although incidental part of a covered physician's service, 3) they must be of kinds commonly furnished in physician's offices, and 4) the services of nonphysicians must be included on the physician's bills.

For CHAMPUS claims, I further certify that I (or any employee) who rendered services am not an active duty member of the Uniformed Services or a civilian employee of the United States Government or a contract employee of the United States Government, either civilian or military (refer to 5 USC 5536). For Black-Lung claims, I further certify that the services performed were for a Black Lung-related disorder.

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (42 CFR 424.32).

NOTICE: Any one who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

NOTICE TO PATIENT ABOUT THE COLLECTION AND USE OF MEDICARE, CHAMPUS, FECA, AND BLACK LUNG INFORMATION (PRIVACY ACT STATEMENT)

We are authorized by CMS, CHAMPUS and OWCP to ask you for information needed in the administration of the Medicare, CHAMPUS, FECA, and Black Lung programs. Authority to collect information is in section 205(a), 1862, 1872 and 1874 of the Social Security Act as amended, 42 CFR 411.24(a) and 424.5(a) (6), and 44 USC 3101; 41 CFR 101 et seq and 10 USC 1079 and 1086; 5 USC 8101 et seq; and 30 USC 901 et seq; 38 USC 613; E.O. 9397.

The information we obtain to complete claims under these programs is used to identify you and to determine your eligibility. It is also used to decide if the services and supplies you received are covered by these programs and to insure that proper payment is made.

The information may also be given to other providers of services, carriers, intermediaries, medical review boards, health plans, and other organizations or Federal agencies, for the effective administration of Federal provisions that require other third parties payers to pay primary to Federal program, and as otherwise necessary to administer these programs. For example, it may be necessary to disclose information about the benefits you have used to a hospital or doctor. Additional disclosures are made through routine uses for information contained in systems of records.

FOR MEDICARE CLAIMS: See the notice modifying system No. 09-70-0501, titled, 'Carrier Medicare Claims Record,' published in the Federal Register, Vol. 55 No. 177, page 37549, Wed. Sept. 12, 1990, or as updated and republished.

FOR OWCP CLAIMS: Department of Labor, Privacy Act of 1974, "Republication of Notice of Systems of Records," Federal Register Vol. 55 No. 40, Wed Feb. 28, 1990, See ESA-5, ESA-6, ESA-12, ESA-13, ESA-30, or as updated and republished.

FOR CHAMPUS CLAIMS: PRINCIPLE PURPOSE(S): To evaluate eligibility for medical care provided by civilian sources and to issue payment upon establishment of eligibility and determination that the services/supplies received are authorized by law.

ROUTINE USE(S): Information from claims and related documents may be given to the Dept. of Veterans Affairs, the Dept. of Health and Human Services and/or the Dept. of Transportation consistent with their statutory administrative responsibilities under CHAMPUS/CHAMPVA; to the Dept. of Justice for representation of the Secretary of Defense in civil actions; to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment claims; and to Congressional Offices in response to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local, foreign government agencies, private business entities, and individual providers of care, on matters relating to entitlement, claims adjudication, fraud, program abuse, utilization review, quality assurance, peer review, program integrity, third-party liability, coordination of benefits, and civil and criminal litigation related to the operation of CHAMPUS.

DISCLOSURES: Voluntary; however, failure to provide information will result in delay in payment or may result in denial of claim. With the one exception discussed below, there are no penalties under these programs for refusing to supply information. However, failure to furnish information regarding the medical services rendered or the amount charged would prevent payment of claims under these programs. Failure to furnish any other information, such as name or claim number, would delay payment of the claim. Failure to provide medical information under FECA could be deemed an obstruction.

It is mandatory that you tell us if you know that another party is responsible for paying for your treatment. Section 1128B of the Social Security Act and 31 USC 3801-3812 provide penalties for withholding this information.

You should be aware that P.L. 100-503, the "Computer Matching and Privacy Protection Act of 1988", permits the government to verify information by way of computer matches.

MEDICAID PAYMENTS (PROVIDER CERTIFICATION)

I hereby agree to keep such records as are necessary to disclose fully the extent of services provided to individuals under the State's Title XIX plan and to furnish information regarding any payments claimed for providing such services as the State Agency or Dept. of Health and Human Services may request.

I further agree to accept, as payment in full, the amount paid by the Medicaid program for those claims submitted for payment under that program, with the exception of authorized deductible, coinsurance, co-payment or similar cost-sharing charge.

SIGNATURE OF PHYSICIAN (OR SUPPLIER): I certify that the services listed above were medically indicated and necessary to the health of this patient and were personally furnished by me or my employee under my personal direction.

NOTICE: This is to certify that the foregoing information is true, accurate and complete. I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State laws.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0008. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

UB-04 CMS-1450 APPROVED OMB NO. 0938-0997  **NUBC**™ National Uniform Billing Committee THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF

UB-04 NOTICE: THE SUBMITTER OF THIS FORM UNDERSTANDS THAT MISREPRESENTATION OR FALSIFICATION OF ESSENTIAL INFORMATION AS REQUESTED BY THIS FORM, MAY SERVE AS THE BASIS FOR CIVIL MONETARY PENALTIES AND ASSESSMENTS AND MAY UPON CONVICTION INCLUDE FINES AND/OR IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW(S).

Submission of this claim constitutes certification that the billing information as shown on the face hereof is true, accurate and complete. That the submitter did not knowingly or recklessly disregard or misrepresent or conceal material facts. The following certifications or verifications apply where pertinent to this Bill:

1. If third party benefits are indicated, the appropriate assignments by the insured /beneficiary and signature of the patient or parent or a legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the patient or the patient's legal representative.
2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.
3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.
4. For Religious Non-Medical facilities, verifications and if necessary re-certifications of the patient's need for services are on file.
5. Signature of patient or his representative on certifications, authorization to release information, and payment request, as required by Federal Law and Regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 through 1086, 32 CFR 199) and any other applicable contract regulations, is on file.
6. The provider of care submitter acknowledges that the bill is in conformance with the Civil Rights Act of 1964 as amended. Records adequately describing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.
7. For Medicare Purposes: If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare medical and non-medical information, including employment status, and whether the person has employer group health insurance which is responsible to pay for the services for which this Medicare claim is made.
8. For Medicaid purposes: The submitter understands that because payment and satisfaction of this claim will be from Federal and State funds, any false statements, documents, or concealment of a material fact are subject to prosecution under applicable Federal or State Laws.
9. For TRICARE Purposes:
 - (a) The information on the face of this claim is true, accurate and complete to the best of the submitter's knowledge and belief, and services were medically necessary and appropriate for the health of the patient;
 - (b) The patient has represented that by a reported residential address outside a military medical treatment facility catchment area he or she does not live within the catchment area of a U.S. military medical treatment facility, or if the patient resides within a catchment area of such a facility, a copy of Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any instance where a copy of a Non-Availability Statement is not on file;
 - (c) The patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverage, and that all such coverage is identified on the face of the claim except that coverage which is exclusively supplemental payments to TRICARE-determined benefits;
 - (d) The amount billed to TRICARE has been billed after all such coverage have been billed and paid excluding Medicaid, and the amount billed to TRICARE is that remaining claimed against TRICARE benefits;
 - (e) The beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,
 - (f) Any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent employees, but excluding contract surgeons or other personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.
 - (g) Based on 42 United States Code 1395cc(a)(1)(j) all providers participating in Medicare must also participate in TRICARE for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987; and
 - (h) If TRICARE benefits are to be paid in a participating status, the submitter of this claim agrees to submit this claim to the appropriate TRICARE claims processor. The provider of care submitter also agrees to accept the TRICARE determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. The provider of care will accept the TRICARE-determined reasonable charge even if it is less than the billed amount, and also agrees to accept the amount paid by TRICARE combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. The provider of care submitter will not attempt to collect from the patient (or his or her parent or guardian) amounts over the TRICARE determined reasonable charge. TRICARE will make any benefits payable directly to the provider of care, if the provider of care is a participating provider.

BCC Medicaid Forms

BCC MEDICAID FORMS

The BCC-Medicaid Application Cover Sheet, Presumptive Eligibility Form, and Request for Transfer Form are used to fax BCC Medicaid applications to the State Women's Health Check office for women with a tissue diagnosis of breast or cervical cancer.

Note: It is important to counsel clients about Medicaid and Estate Recovery prior to submitting a BCC Medicaid application.

CONFIDENTIAL FAX

To: Julie Orgill Women's Health Check	From: Phone:
FAX: (208) 334-0657	Date: Pages:



BCC-MEDICAID APPLICATION COVER SHEET

All documents must be complete, and LEGIBLE

CHECK LIST:

- ☐ WHC Enrollment form (current)
- ☐ Presumptive Eligibility form
 - Counsel client regarding the transition from WHC to BCC Medicaid -
 - Including Estate Recovery
 - Breast or cervical cancer section –
 - Date and result of Pap/ CBE /Mammogram
 - Date and result of biopsy**, final diagnosis
 - Initial plan of care
 - List surgeon, oncology and/or radiation physicians
 - Treatment start date if known – or TB Determined
 - Physician name(s) and phone numbers
 - Case Manager's signature and phone number
- ☐ Insurance information (if applicable)
- ☐ Alien document with **Alien ID #** (if applicable)
- ☐ Pathology (**biopsy**) report
- ☐ Relevant physician/clinician reports and notes

Applications without a biopsy report are not valid.

Confidentiality Notice:

This message is intended only for the individual or entity to which it is addressed and may contain information that is privileged, confidential and exempt from disclosure under federal law. If the reader of this message is not the intended recipient, or the employee responsible for delivering message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. **If you have received this communication in error, please notify me immediately and destroy documents.**

Presumptive Eligibility Form

Idaho – Medicaid

vers. (07.2007)

Women's Health Check
PO Box 83720 4th Floor
BOISE, ID 83720-0036



Client Name: _____
Last (Print) First MI

Date of Birth: (____/____/____)
Month Day Year

Age: ____ Date of Initial WHC Enrollment: (____/____/____) Social Security #: ____ - ____ - ____
Month Day Year

- ☐ Client was found to need treatment for breast or cervical cancer
☐ Screening and Diagnostic services were provided through Women's Health Check
☐ Client is a U.S. Citizen
☐ Client is not a U.S. Citizen. Alien# is: _____
☐ Client has no health insurance.
☐ Client has health insurance. Copy of Insurance Card attached.

Breast Cancer

Date of clinical breast exam: (____/____/____)
Month Day Year

CBE results: _____

Date of mammogram: (____/____/____)
Month Day Year

Mammogram results: _____
Month Day Year

Date of biopsy: (____/____/____)

Biopsy results: _____

Final diagnosis:

- ☐ Carcinoma *in situ* ☐ Lobular Carcinoma *in situ*
☐ Ductal Carcinoma *in situ* ☐ Invasive Breast Cancer

Cervical Cancer

Pap Smear results: _____

Date of Pap Smear: (____/____/____)
Month Day Year

Date of biopsy: (____/____/____)
Month Day Year

Biopsy results: _____

Final diagnosis:

- ☐ LG SIL (CIN I/Mild dysplasia) - treatment recommended
☐ HG SIL (CIN II/Moderate dysplasia)
☐ HG SIL (CIN III/Severe dysplasia/CIS)
☐ Carcinoma

Initial Plan of Care

Physician (Print)

Telephone

Appointment Date

- ☐ Surgery _____
☐ Radiation _____
☐ Chemotherapy _____
☐ Other _____

Treatment Start Date: (____/____/____)
Month Day Year

I have informed the above named WHC client of her referral to BCC Medicaid for treatment. The client has received the appropriate information regarding BCC Medicaid, her diagnosis and treatment plan.

Client received information: ☐ in person ☐ by phone ☐ by mail

Certified by (Women's Health Check, Local Case Manager) _____

Phone _____

Date _____

Approved by (Women's Health Check, state office) _____

Date _____

National Breast and Cervical Treatment Act Request for Transfer Form



Idaho

Instructions: Clients diagnosed through another state or tribe funded by the Centers of Disease Control (CDC) National Breast and Cervical Cancer Early Detection Program (NBCCEDP) may request a transfer from that state's Medicaid system to Idaho. Submit the following for review prior to acceptance:

1. **Idaho WHC Enrollment Form**
2. **Presumptive Eligibility Form Idaho – Medicaid**
3. **Breast and Cervical Cancer Medicaid Verification Form**
4. **Request for Transfer Form – Date of diagnosis, current treatment status, physician**
5. Submit forms and information to a local WHC coordinator, or the state WHC office:
Women's Health Check
450 West State Street – 4th Floor
PO Box 83720
Boise, ID 83720-0036 Telephone: 208 334-5971 FAX 208 334-0657
6. Enrollment will be approved based upon **Idaho eligibility requirements** and **treatment status**.
Idaho requirements may be different from original enrollment state.

Client Name (Last, First, M.I.) _____

Birth Date _____

Social Security #: _____ - _____ - _____

Previous Address (City) _____ (State) _____

Previous NBCCEDP affiliate (State or Tribe): _____

Date of Enrollment at previous site: _____ Date of Diagnosis: _____

Name of Physician _____ Phone Number _____

Current Treatment: _____

I consent to the release of my information to the Idaho Department of Health and Welfare Women's Health Check and Medicaid for the purpose of determining eligibility and transfer of records to Idaho Medicaid for the duration of active treatment for breast or cervical cancer, diagnosed through another affiliate of the NBCCEDP.

Signature: _____

Date: _____

Resources

RESOURCES

This is a brief list of useful websites and reports regarding cancer. Specific resources related to breast or cervical cancer can be found in following sections.

REPORTS

National Breast and Cervical Cancer Early Detection Program
1991-2002 National Report

<http://www.cdc.gov/cancer/nbccedp/Reports/NationalReport/index.htm>

PUBLIC HEALTH

The Guide to Clinical Preventive Services

<http://odphp.osophs.dhhs.gov/pubs/guidecps/>

Centers for Disease Control and Prevention Cancer Web Site

www.cdc.gov/cancer

Cancer Information Service

<http://cis.nci.nih.gov/>

American Cancer Society

<http://www.cancer.org>

RESOURCES FOR BREAST CANCER

This is a brief list of useful websites and reports regarding breast and cervical cancer screening.

RESOURCES FOR BREAST CANCER

PROFESSIONAL:

American College of Radiology – Bi-Rads Atlas

http://www.acr.org/s_acr/sec.asp?CID=97&DID=142

National Comprehensive Cancer Network – Clinical Practice Guidelines in Oncology
Breast Cancer Screening and Diagnosis Guidelines version 1.2005

http://www.nccn.org/professionals/physician_gls/PDF/breast-screening.pdf

American Cancer Society

www.cancer.org

National Cancer Institute

<http://www.cancer.gov/cancertopics/types/breast>

U.S. Preventive Services Task Force

Pocket Guide to Clinical Preventive Services

<http://www.preventiveservices.ahrq.gov/>

Centers for Disease Control & Prevention

www.cdc.gov/cancer/nbccedp/info-bc.htm

National Cancer Institute

Breast Cancer (PDQ®): Screening (Health Professional Version)

www.cancer.gov/cancertopics/pdq/screening/breast/healthprofessional/allpages/print

Digital vs. Film Mammography in the Digital Mammographic Imaging Study (DMIST): Questions & Answers

www.cancer.gov/newscenter/pressreleases/DMISTQandA

Public Health Grand Rounds

Breast Cancer Screening: More than Just Mammograms (webcast)

<http://publichealthgrandrounds.unc.edu/brcancer/index.htm>

MedLine Plus (National Library of Medicine)

Breast Cancer Home Page

www.nlm.nih.gov/medlineplus/breastcancer.html

Guide to Clinical Preventive Services

<http://odphp.osophs.dhhs.gov/pubs/guidecps/>

PATIENT:

American Cancer Society

www.cancer.org

Brochures of Interest:

- After Diagnosis: A Guide for Patients and Families English (#9440)
- Breast Cancer Dictionary English (#4675)

- Breast Cancer Treatment Guidelines for Patients, Version VI English/Spanish (#9405/9406)
- Sexuality & Cancer: For the Woman Who Has Cancer & Her Partner English (#4657)

Centers for Disease Control & Prevention

www.cdc.gov/cancer/nbccedp/info-bc.htm

National Cancer Institute

<http://www.cancer.gov/cancertopics/types/breast>

Brochures of Interest:

What You Need to Know About Breast Cancer

www.cancer.gov/cancertopics/wyntk/breast

Understanding Breast Changes: A Health Guide for All Women

www.cancer.gov/cancertopics/understanding-breast-changes

Breast Cancer (PDQ®): Screening (Patient Version)

www.cancer.gov/cancertopics/pdq/screening/breast/patient/allpages/print

Fact Sheet: Screening Mammograms: Questions & Answers

<http://www.cancer.gov/cancertopics/factsheet/Detection/screening-mammograms>

Fact Sheet: Improving Methods for Breast Cancer Detection & Diagnosis

<http://www.cancer.gov/cancertopics/factsheet/Detection/breast-cancer>

MedLine Plus (National Library of Medicine)

Breast Cancer Home Page

www.nlm.nih.gov/medlineplus/breastcancer.html

Young Survival Coalition

<http://www.youngsurvival.org/young-women-and-bc/resources/>

RESOURCES FOR CERVICAL CANCER

This is a brief list of useful websites and reports regarding cervical cancer.

RESOURCES FOR CERVICAL CANCER

PROFESSIONAL:

National Comprehensive Cancer Network – Clinical Practice Guidelines in Oncology
Cervical Screening version 1.2005

http://www.nccn.org/professionals/physician_gls/PDF/cervical_screening.pdf

American Society for Colposcopy and Cervical Pathology
Consensus Guidelines

<http://www.asccp.org/>

American Cancer Society

www.cancer.org

National Cancer Institute

www.cancer.gov/newscenter/pressreleases/cervicalscreen

Cervical Cancer (PDQ®): Screening (Health Professional Version)

www.cancer.gov/cancertopics/pdq/screening/cervical/healthprofessional/allpages/print

U.S. Preventive Services Task Force

www.ahrq.gov/clinic/uspstf/uspscerv.htm

Centers for Disease Control and Prevention

www.cdc.gov/cancer/cancer/nbccepd/info-cc.htm

Guide to Clinical Preventive Services

<http://odphp.osophs.dhhs.gov/pubs/guidecps/>

MedLine Plus (National Library of Medicine)

Cervical Cancer Home Page

www.nlm.nih.gov/medlineplus/cervicalcancer.html

PATIENT:

American Cancer Society

www.cancer.org

National Cancer Institute

www.cancer.gov/newscenter/pressreleases/cervicalscreen

Brochures of Interest:

What You Need to Know About Cancer of the Cervix

www.cancer.gov/cancertopics/wyntk/cervix

Understanding Cervical Changes: A Health Guide for Women

www.cancer.gov/cancertopics/understandingcervicalchanges

Cervical Cancer (PDQ®): Screening (Patient Version)

www.cancer.gov/cancertopics/pdq/screening/cervical/patient/allpages/print

Fact Sheet: Pap Test: Questions & Answers

<http://www.cancer.gov/cancertopics/factsheet/Detection/Pap-test>

Pap Tests and Cervical Health: A Health Habit for You

<http://www.cancer.gov/cancertopics/pap-tests-cervical-health>

Pap Tests for Older Women

<http://www.cancer.gov/cancertopics/pap-tests-older-women>

Centers for Disease Control and Prevention

www.cdc.gov/cancer/cancer/nbccepd/info-cc.htm

MedLine Plus (National Library of Medicine)

Cervical Cancer Home Page

www.nlm.nih.gov/medlineplus/cervicalcancer.html

Glossary

GLOSSARY OF TERMS/ABBREVIATIONS

American College of Radiology Accreditation (ACR)

A voluntary mammography accreditation program has become one of the standards for quality assurance. The following major areas are assessed:

- Personnel qualifications and experience
- Equipment specification and technical procedures
- Quality assurance practices
- Evaluations of mammograms from the applicants practice and through the use of phantom images

Aspiration Biopsy

A procedure in which a specimen for biopsy is removed by aspirating it through an appropriate needle that pierces the skin and penetrates into the underlying tissue to be examined. (Also see Fine Needle Aspiration) or A procedure where an appropriate needle pierces the skin penetrating into the underlying tissue to be examined and a specimen for biopsy is removed by aspiration.

Benign

This is not malignant; not recurrent; favorable for recovery; not cancer. The main types of benign breast problems are fibroadenoma, fibrocystic changes and cysts.

Bethesda System

A method for the reporting and classification of Pap smear specimens, developed in December 1988. The Clinical Laboratory Improvement Act (CLIA) regulations mandate the use of the Bethesda System for laboratory reporting and proficiency testing.

Biopsy

The removal and examination (by a pathologist) of tissue samples, cells, or fluids from a living body. An examination of the appearance of the tissue under a microscope is done to find out if cancer or other abnormal cells are present. The biopsy can be done with a needle or by surgery.

BIRAD

Uniform reporting system for mammography results.

Breast Cancer

Cancer that begins in the breast. The main types of breast cancer are Ductal Carcinoma in Situ, Infiltrating Ductal Carcinoma, Lobular Carcinoma in Situ, Medullary Carcinoma and Paget's disease of the nipple.

Breast Self Examination (BSE)

A technique of checking your own breasts for lumps or suspicious changes.

Carcinoma

This is a malignant tumor that begins in the lining (epithelial) cells of organs. Epithelial cells are those which cover the surfaces of tissue. It can occur in any part of the body. 80% or more cancers and all breast cancers are carcinoma.

Carcinoma in Situ

An early stage of cancer in which the cancer is still only in the structures of the organ where it developed and the disease has not invaded other parts of the organ or spread. Most are highly curable. Also called cancer in situ and preinvasive.

Case Manager

The member of the cancer care team who is the “referee.” This person coordinates all of the services needed by the client throughout diagnosis, treatment, and recovery.

Clinical Breast Examination (CBE)

A physical examination of the breasts performed by a physician, nurse or physician’s assistant.

Cervical Intraepithelial Neoplasia (CIN)

A cellular change to the mouth of the cervix which may include severe dysplasia and CIS. CIN III is the most severe of the three-category classification system.

Colposcope

An instrument used to examine the tissues of the vagina and cervix through a magnifying lens.

Colposcopy

Diagnostic procedure performed with a Colposcope through a magnified view of the vagina/cervix to visualize abnormal epithelium for biopsy and/or removal in clients with abnormal pap smears. Cervical biopsies are usually done through colposcopic examination.

Cone Biopsy

The removal of the cone shaped piece of tissue from the cervix. This is a more definitive procedure than a cervical biopsy. It is used when abnormal cells extend up into the cervical opening or through the tissue.

Conization

The process of removing a cone of tissue, as in partial excision of the cervix uteri. Cold Conization is done with a cold knife to better preserve the histologic elements.

Contractors

Idaho Health Districts, clinics, hospitals and other health-related agencies that contract directly with the State Women’s Health Check Program (WHC) to coordinate breast and cervical cancer early detection services and data. Each contractor must have formal agreements or subcontracts with all providers for WHC services.

Cryosurgery

This is the destruction of tissue by exposing tissues to extreme cold in order to produce well-demarcated areas of cell injury and destruction. Used to treat malignant tumors, control pain, produce lesions in the brain, and control bleeding.

Diagnostic Mammogram

Defined by the American College of Radiology as “mammography performed on women who, by virtue of symptoms or physical findings, are considered to have a substantial likelihood of having breast disease.”

Ductal Carcinoma in Situ

Cancer cells that started in the milk ducts and have not penetrated the duct walls into the surrounding tissue. This is a highly curable cancer form of breast cancer that is treated with surgery.

Dysplasia

This is an abnormality in size, appearance and organization of adult cells. A biopsy is needed for diagnosis.

Endocervical Curettage (ECC)

The surgical scraping of the lining of the uterine cervix.

“Every Woman Matters” Legislation

Idaho law that allows women diagnosed with breast or cervical cancer through the Women’s Health Check program to apply for Medicaid (if eligible) while receiving active treatment.

Fibroadenoma

An adenoma in the breast, composed of fibrous tissue. On clinical examination or BSE, it feels like a firm lump. These usually occur in young women and are benign.

Fibrocystic Changes

A term that describes certain benign changes in the breast. Symptoms are breast swelling or pain. Signs are nodules, lumpiness and nipple discharge. Not cancerous.

Federal Poverty Level (FPL)

This measurement is updated annually based on the last calendar year’s increase in prices as measured by the Consumer Price Index. A woman is eligible for the Women’s Health Check program if her income is at or below 200% of the FPL.

Grade

The classification of the severity of a disease.

Human Papillomavirus (HPV)

A sexually transmitted virus implicated in the pathogenesis of cervical cancer and its pre-cursor lesions.

High-Grade Squamous Intraepithelial Lesion (HSIL)

The Bethesda System classification for a Pap smear result that includes cellular changes of moderate to severe dysplasia (CIN II and III / CIS).

Hyperplasia

An abnormal increase in the number of cells in a specific area, such as the lining of the breast ducts. This overgrowth may be due to hormonal stimulation, injury or continuous irritation. It is not cancerous by itself, but when the proliferating cells are atypical the risk of cancer developing is greater.

Infiltrating Ductal Carcinoma

A cancer that starts in the milk passages of the breasts (ducts) and then breaks through the duct wall, where it invades the fatty tissue of the breast. When it reaches this point, it has the potential to spread or metastasize elsewhere in the breast, as well as to other parts of the body through the bloodstream and lymphatic system. Infiltrating ductal carcinoma is the most common type of breast cancer, accounting for about 80% of breast malignancies.

Invasive Cancer

This is a cancer that has invaded surrounding tissue and spread to distant parts of the body.

Invasive Cervical Carcinoma

Infiltration of cancer cells into the tissue beyond the epithelium of the cervix. This term indicates that a malignant growth extends deeper than 3 mm into the stroma.

Invasive Lobular Carcinoma

A cancer that arises in the milk-producing glands of the breast and then breaks through the lobule walls. From this site it may spread elsewhere in the breast. 15% of invasive breast cancer is ILC. It is often difficult to detect by physical examination or even by mammography. Up to 25% of women with this type of cancer will at some point develop an additional cancer in the opposite breast.

Local Coordinating Contractor (LCC)

Health District, contracting clinic, hospital or other health related agency that contracts with State of Idaho Dept. of Health and Welfare, Women’s Health Check program to coordinate local services and report client data.

Loop Electrosurgical Excision Procedure (LEEP)

A surgical procedure used on the cervix by which an electrical current generating a radio frequency, is passed through a wire loop, which is then drawn around the cervical opening to excise the tissue. The procedure can usually be performed in an outpatient setting with the use of local anesthesia. (Procedure not paid for by WHC.)

Lobular Carcinoma in Situ (LSIL)

A very early type of breast cancer developing within the milk-producing glands (lobules) of the breast and does not penetrate through the wall of the lobules. Researchers think that lobular carcinoma in situ does not eventually become an invasive lobular cancer. They believe, instead, that it places women at an increased risk of developing an invasive breast cancer later in life. This makes it important for women with lobular carcinoma in situ to have a physical examination three to four times per year and an annual mammogram.

Lobular Carcinoma (infiltrating or invasive)

A type of breast cancer that starts within the lobules. It may be multicentric (occurring in multiple lobules). Compared with other types of breast cancer, this type has a higher chance of occurring in the opposite breast as well. It can often be difficult to diagnose, even with careful physical examination or mammography.

Low-Grade Squamous Intraepithelial Neoplasia (LSIL)

The Bethesda System classification for a Pap smear result, which includes cellular changes of HPV, mild dysplasia (CIN I).

Lumpectomy

Removal of the breast lump plus a margin of normal tissue around it. If tissue is found to be malignant, radiation therapy or mastectomy often follows it. Also called Limited Breast Surgery.

Mammography Quality Standards Act of 1992 (MQSA)

The national accreditation of mammogram units through the FDA.

MDE (Minimum Data Elements)

Clinical data items submitted to CDC two times a year.

Metaplasia

This is an abnormal replacement of cells of one type by cells of another type. This does not represent a malignant or premalignant condition.

Metastasis

The spread of cancer cells to distant areas of the body by way of the duct extension, lymph system or bloodstream.

National Breast and Cervical Cancer Early Detection Program (NBCCEDP)

National breast and cervical cancer screening program funded by the Centers for Disease Control and Prevention. Idaho's program is known as Women's Health Check.

Needle Aspiration

Removal of fluid from a cyst or cells from a tumor. In this procedure, a needle and syringe (like those used to give injections) is used to pierce the skin, reach the cyst or tumor, and with suction, draw up (aspirate) specimens for biopsy analysis. If the needle is thin, the procedure is called Fine Needle Aspiration (FNA).

Needle Localization

A procedure used to do a breast needle biopsy, when the lump is difficult to locate or in areas that look suspicious on the x-ray but do not have a distinct lump. After an injection of local anesthesia to numb the area, a thin needle is inserted into the breast. X-rays are taken and used to guide the wire to the area to be biopsied. A tiny hook on the end of the wire holds it in place. Then a hypodermic needle (like the type used to give injections) is inserted, using the path of the wire as a guide, and the biopsy is completed. (Also see Needle Aspiration)

Neoplasia

The pathologic process that results in the formation and growth of a neoplasm. This neoplasm is a new growth or tumor, which may be benign or malignant.

Neoplasm

Any abnormal growth; neoplasms may be benign or malignant. Cancer is a malignant neoplasm.

Nipple Discharge

Any fluid coming from the nipple. It may be clear, milky, bloody, tan, gray, or green.

Nodule

A small, solid lump that can be located by touch.

Pap (Papanicolaou) Smear (Pap Test)

This is a screening test of the cells of the cervix used to detect early signs of cervical cancer.

Premalignant

Abnormal changes in cells that may, but not always, become cancer. Most of these early lesions respond well to treatment and result in cure. Also called precancerous.

Protocol

This is a formalized outline or plan.

Providers

Health Care Professionals, labs, mammography centers, or hospitals that contract with the State of Idaho Department of Health and Welfare, Women's Health Check program to provide services for WHC clients. Listed services for enrolled clients are reimbursed at Medicare rates.

Reactive Changes

Normal changes in tissue as a result of the body's reaction to an irritation or infectious agent.

Rescreening

The process of returning for cancer screening test (clinical breast exam, mammogram, Pap test) at a predetermined interval – usually once per year.

Screening Mammogram

American College of Radiology defines a screening mammogram as an "x-ray breast examination of asymptomatic women in an attempt to detect breast cancer, when it is small, nonpalpable and confined to the breast."

Screening Services

Refers to clinical breast examination, Pap smear, pelvic examination, mammography, colposcopy, colposcopy directed biopsy, fine needle aspiration, instruction in breast self-examination and informational and educational services relating to breast and cervical cancer.

Squamous Cell Carcinoma

Develops from squamous epithelium. Initially local and superficial, may later invade and metastasize.

Staging

A method of determining and describing the extent of cancer, based on the size of the tumor, whether regional axillary lymph nodes are involved, and whether distant spread (metastasis) has occurred. Knowing the stage at diagnosis helps decide the best treatment and the prognosis.

Stages of Breast Cancer (FIGO/AJCC (1988))

- Stage 0: The earliest type of breast cancer; the disease is in situ.
- Stage I: The tumor is less than 1 inch in diameter and has not spread beyond the breast.
- Stage II: The tumor is about 1-2 inches in diameter and/or has spread to the lymph nodes under the arm (axillary lymph nodes).
- Stage III: The tumor is about 2 inches or larger and may have spread to axillary lymph nodes, and/or to other lymph nodes, or to other tissues near the breast.
- Stage IV: The cancer has spread (metastasized to other organs of the body).

Stereotactic Biopsy

A diagnostic procedure that combines the technology of radiological imaging with surgical biopsy. This procedure may be used to obtain tissue from a lesion that is probably benign, but has changed during repeated mammograms, and the patient wishes to avoid more extensive excisional surgery. It is often used to obtain tissue for biopsy from suspicious clusters of mammographic calcifications.

Suspicious Abnormality

A finding on a test that indicates cancer might be present.

Third Party Administrator (TPA)

Agency that reviews and pays all claims from providers for the Women's Health Check Program.

US - Ultrasonography (ultrasound)

An imaging method in which high-frequency sound waves are used to outline a part of the body. It is useful in detecting breast cysts in young women with firm, fibrous breasts. No radiation exposure occurs.

Within Normal Limits (WNL)

An interpretation of a cervical cancer screening or diagnostic procedure result, and it indicates negative findings.

Women's Health Check (WHC)

Idaho's program to implement the National Breast and Cervical Early Detection Program managed and funded through CDC.

Women's Health Check Real Time (WHCRT)

Idaho's web-based system used to document results of all procedures, assist with follow-up, and case management.

Contact Information

NATIONAL BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM¹

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP) is a nationwide, comprehensive public health program that helps uninsured and underserved women gain access to screening services for the early detection of breast and cervical cancer.

Breast cancer is the most commonly diagnosed cancer and the second leading cause of cancer death among women in the United States. Screening for and early detection of breast and cervical cancer reduces death rates and greatly improves cancer patients' survival. However, there is a disproportionately low rate of screening among women of certain racial and ethnic minorities and among under- or uninsured women, which creates a wide gap in health outcomes between such women and other women in the United States. To address this health disparity, Congress authorized the NBCCEDP in 1990, giving CDC the ability to implement a national strategic effort to increase access to mammography and Pap test screenings for women in need.

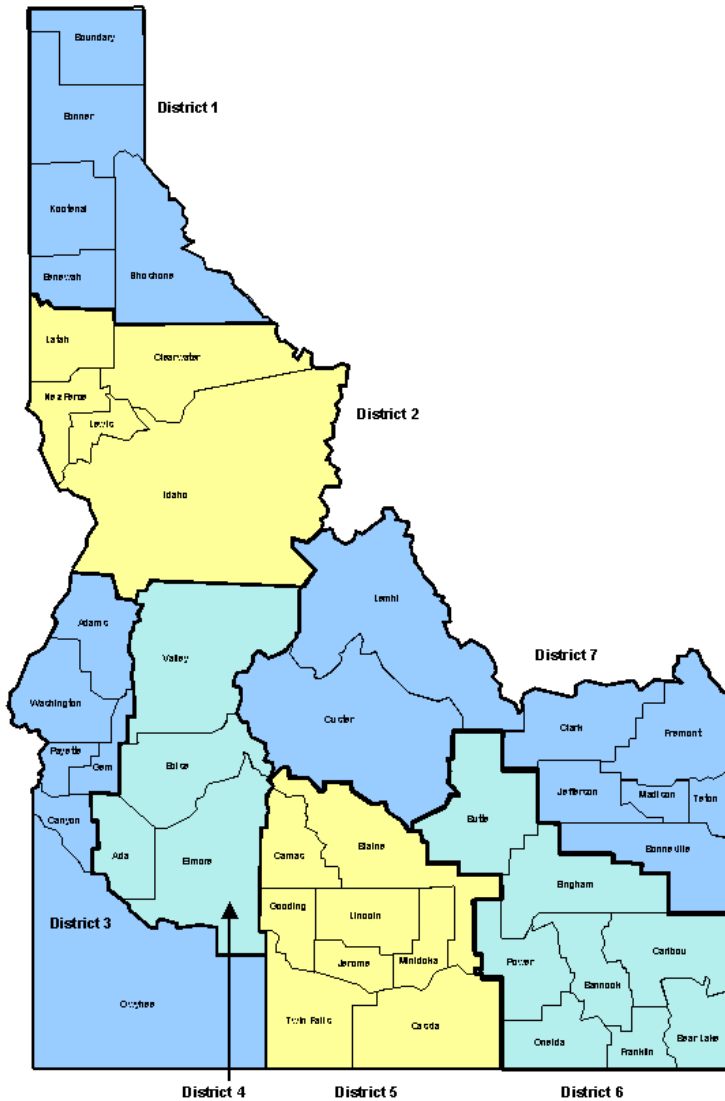
The NBCCEDP is implemented through cooperative agreements with state and territorial health departments, tribes, and tribal organizations (grantees). Sixty percent of federal funds received by a grantee must be expended on direct services for women. The other 40% of federal funds can be used to support program management, public and provider education, quality assurance, and surveillance and evaluation activities. The NBCCEDP is intended to be the payer of last resort for screening services; therefore, grant monies cannot be used to pay for services if other coverage is available through any state fund, private health insurance, or other government health benefits program such as Medicaid or Medicare. Grantees are also required to maintain and document matching effort, \$1 for every \$3 of federal funds. Grantees contract with a broad range of provider agencies to deliver screening and other services, and each grantee has developed its own delivery system based on available resources.

The NBCCEDP is directed to low-income, uninsured women aged 18–64 from priority populations. The program provides clinical breast examinations, mammograms, and Pap tests for eligible women who participate in the program as well as diagnostic testing for women whose screening outcome is abnormal. Although treatment services are not directly paid for by the NBCCEDP, programs have always been required to identify resources for the treatment of breast and cervical cancer found through the program. To assist programs in identifying these resources, in 2000 Congress gave the states the option to provide medical assistance for treatment through Medicaid (PL 106-354). In addition to screening and diagnostic services, the legislation authorizing the NBCCEDP (PL 101-354) provided for public and professional education, quality assurance, and surveillance and evaluation systems to monitor program activities. Each grantee reports to CDC a subset of program data known as the minimum data elements (MDEs). The MDEs are a set of standardized data elements considered to be minimally necessary for grantees and CDC to monitor client demographics and clinical outcomes of women screened with NBCCEDP funds. The MDEs also are used to establish NBCCEDP policies and practices, assess the national program's screening outcomes, and respond to the information needs of CDC stakeholders and partners.

To access information on a specific state, territory or American Indian/Alaska Native organization:
<http://apps.nccd.cdc.gov/cancercontacts/nbccedp/contacts.asp>

¹Centers for Disease Control and Prevention. *The National Breast and Cervical Cancer Early Detection Program 1991–2002 National Report*. Atlanta (GA): Department of Health and Human Services; 2005.

WOMEN'S HEALTH CHECK CONTRACTORS



WOMEN'S HEALTH CHECK
LOCAL COORDINATING CONTRACTORS
IDAHO HEALTH DISTRICTS

	District	Address	Phone	Fax	Coordinator
1	Panhandle District Health	8500 N. Atlas Road Hayden, ID 83835	415-5100	451-5101	Gail Turley
2	North Central District Health	215 10th St. Lewiston, 83501	799-3100	799-0349	Susan Stutzman Dianne Waldermarson
3	Southwest District Health	1008 E Locust Emmett, 83617 920 Main St. Caldwell, 83605	365-6371-E 455-5300-C 549-2370-W	365-4729 -E 455-5386-C 549-2371-W	Debbie Dobbs
5	South Central Public Health District	1020 Washington St. N. Twin Falls, 83301-3156	737-5935	734-9502	Debbie Parrish
6	Southeast District Health	1901 Alvin Ricken Drive Pocatello, 83201	239-5232	478-9297	Julie Fagnant
7	Eastern Idaho Public Health District	1250 Hollipark Dr Idaho Falls, 83401	522-0310 x129	525-7063	Pat Fletcher

OTHER LOCAL COORDINATING CONTRACTORS

Facility	Address	Phone	Fax	Coordinator
Terry Reilly Health Services	223 16th Avenue North Nampa, 83653	466-7869	466-5359	Roxanne Ohlund (318-1260)
Family Medicine Health Center	777 North Raymond Boise, ID 83704	367-6638	947-0913	Tonya Bowers
St. Alphonsus Breast Care Center	6200 W. Emerald Boise, Idaho 83704	367-8332	367-3390	Cynthia Benson



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